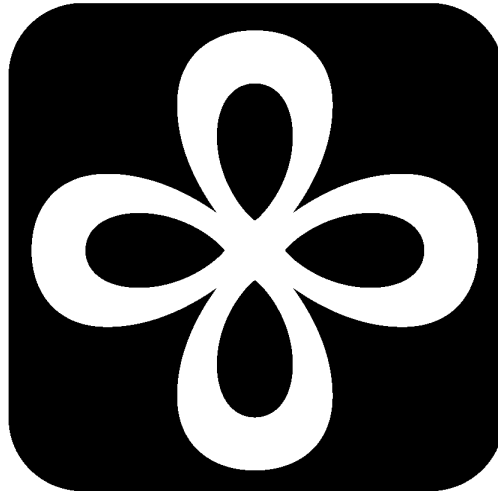


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID



Provider Manual

HCBS Mental Retardation Waiver



CHAPTER E. COVERAGE AND LIMITATIONS

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 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS HCBS MENTAL RETARDATION WAIVER	CHAPTER PAGE E - 1
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I. THE HOME- AND COMMUNITY-BASED MR WAIVER PROGRAM

This chapter describes the federal and state Medicaid requirements a provider must meet to participate in the home- and community-based services (HCBS) mental retardation (MR) waiver program.

The Medicaid HCBS waiver programs were established by Congress in 1981. Congress gave the Health Care Financing Administration in the federal Department of Health and Human Services oversight of the HCBS waiver programs.

In 1987, Congress expanded the waiver programs through the Omnibus Budget Reconciliation Act (OBRA). OBRA '87 established that persons who reside in nursing homes and who meet assessment criteria for specialized services (formerly known as active treatment) could access the waiver programs.

Waiver programs allow states to access Medicaid funding to develop and implement an array of community-based services. The services offered through each waiver program must meet public standards for the health, safety, and welfare of the consumers. These services are directed to Medicaid-eligible persons who require a level of care previously provided only in a hospital or nursing facility.

With home- and community-based services, eligible persons are able to remain in or return to their own homes and attain the highest degree of independence possible. The HCBS waiver programs differ from other Medicaid services in that access to services is permitted on an individualized basis and the services are consumer-driven.

The services offered through each waiver are used in flexible combinations to meet the needs of each consumer. A consumer may receive a combination of waiver services or a combination of waiver and non-waiver services.

Case management, service coordination, and monitoring must ensure that the needs of the consumers are met. However, the services provided through each waiver program must be limited to only those services required to meet the consumer's individualized needs.



The HCBS MR waiver was approved for implementation March 1, 1992. The MR waiver is for people with a diagnosis of mental retardation. The waiver may serve:

- ◆ People who reside in nursing homes or ICFs MR and are moving into the community.
- ◆ People who are diverted from placement into these facilities.

The Iowa Department of Human Services, Bureau of Long Term Care, administers the HCBS waiver programs. The Bureau of Long Term Care operates under a federally approved State Medicaid Plan. The State Medicaid Plan requires provider certification to ensure that standards for home- and community-based services are met.

The Bureau assigned responsibility to its Bureau of Health Care Purchasing and Quality Management for the certification of providers and the ongoing administration of the waiver programs. The Bureau contracts with Iowa State University for staff assistance.

HCBS specialists from Iowa State University have the regulatory responsibility of quality assurance and for making recommendations to the Bureau of Long Term Care regarding provider certification.


HCBS specialists also provide technical assistance upon request to consumers and their families, service providers, case management agencies, county boards of supervisors, and Department of Human Services staff.

Technical assistance is available throughout the entire process of application, certification or recertification by contacting the waiver services office at (515) 281-8061.

A. Provider Enrollment

To apply for certification as a waiver service provider, contact the Medicaid fiscal agent, ACS, by phone at 800-338-7909 or in writing at:

ACS
Provider Relations
PO Box 14422
Des Moines, IA 50306-3422

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You will receive an application packet containing:

- ◆ Form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion,
- ◆ Form 470-2965, *Agreement Between Provider of Medical and Health Services and Iowa Department of Human Services Regarding Participation in Medical Assistance Program*, and
- ◆ Form W-9, *Request for Taxpayer Identification Number and Certification*.

Submit the completed application to the **same office**. The fiscal agent must receive your application for certification at least 90 days before your planned implementation date.


HCBS specialists review the submitted application. They will contact you if they require additional information or clarification. This may include:

- ◆ Your current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.
- ◆ Your fiscal capacity to initiate and operate the specified programs on an ongoing basis.
- ◆ Your written agreement to work cooperatively with the state and central point of coordination in the counties you will serve.

HCBS specialists have 60 days from the receipt of your application to determine whether you meet the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

Note: If your agency has met certification, accreditation, or approval from outside entities which the Department has established as adequate to enroll as a waiver provider, the HCBS specialist will enroll the agency for that particular service under the MR waiver. This is possible for providers of the following services:

- ◆ Consumer-directed attendant care
- ◆ Home health aide
- ◆ Nursing care
- ◆ Respite care

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Other services may be certified or deemed depending on rule requirements.

Enrolled agencies are required to maintain compliance with standards as found in the Iowa Administrative Code. The IAC changes periodically and it is the responsibility of enrolled agencies to stay current with the changes and meet all standards regarding enrollment requirements. Reviews are not generally conducted.

If a review of an agency's policies or procedures is required to determine if there is substantial compliance with current HCBS standards or to determine if substantial compliance with outcome-based standards has been met following an on-site review, the HCBS specialist will certify an agency for a particular service(s).

HCBS Specialists may conduct an on-site review at their discretion. This may include on-site case record audits, review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation, interviews with staff, consumers, board of directors, or others deemed appropriate.

B. Facsimile of Form 470-2917

See the following pages for a facsimile of form 470-1917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion.

INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

I. GENERAL SECTION

- 1-7 Enter the current provider number, name, and the address of the provider of service. If the billing address is different than the street address, attach the “pay to” address to the form.
- 8-9 **County Name and Number.** Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).
- 10 **Phone.** Enter area code and phone number.
- 11 **Fax.** Enter area code and fax number, if available.
- 12 **E-mail address.** Enter email address, if available. By providing us with your email address, you agree that we may communicate with you by electronic mail.
- 13 **Desired Effective Date for Enrollment.** Cannot be retroactive before the first of the month in which the application was signed. Providers cannot bill or be paid for service provided prior to DHS agreement to the service.
- 14 **HCBS Waiver.** Indicate the HCBS waiver program(s) for which application is being made.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

If you are applying on behalf of an agency, proceed to section III.

If you are an individual applying for services other than Consumer-Directed Attendant Care, proceed to Section III (**this is not common!**).

- 15 **Social Security Number.** Enter your social security number here.
- 16 Indicate that you are applying for Consumer-Directed Attendant Care. Indicate whether you are going to provide the service on the daily or hourly basis (or both).
- Individuals who apply to provide Consumer-Directed Attendant Care are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver’s license. The date of birth must be clearly visible or it will not be accepted.
 - All of the forms must be completed. Individuals must fill out the W-9 form. All taxes on income earned from providing CDAC services are the responsibility of the individual providing the service.

Note: The CDAC provider cannot bill or be paid for service provided prior to Department of Human Service written approval of this service. That is indicated by the DHS service worker attaching the HCBS Consumer Directed Attendant Care Agreement, form 470-3372, to the service plan in the Ill and Handicapped, AIDS/HIV, and Elderly and Physical Disability waivers. In the Brain Injury and Mental Retardation waivers, the CDAC Agreement is attached to the service plan and sign off is obtained by sending a form 470-0379 to the Division of Long Term Care in DHS central office. Any payments made prior to the DHS written approval of this service are fraud, and referrals for recovery and prosecution of this federal offense will be made.

- 17 **Signature.** Original signature required. Applications not properly signed will be returned.
- 18 **Date.** Enter date application is signed.

III. AGENCIES APPLYING FOR WAIVER SERVICES

- 15 **Tax ID Number.** Enter your IRS Tax ID number.
- 16 **Contact Person.** Enter the name of the person who should be contacted for questions in regards to the application.
- 17-21 Self-explanatory.
- 22 **Claims in Process Information.** Paid and denied claims will automatically be reported to you. You have three choices regarding suspended claims, i.e. claims currently in process pending resolution of one or more issues. Those choices are:
- Y = Print suspended claims only once. You will be notified only once that we have received your claim and that it is in process. You will not be notified about the claim again until it either pays or denies.
- A = Print all suspended claims until paid or denied. You will be notified every week about all claims that are in process.
- N = Do not print suspended claims. You will receive no notice concerning claims in process until they either pay or deny.
- 23 **Remittance Sequence.** Choose which sequence your claims will be reported to you. The choices are:
- By Recipient Name.* Claims will be reported in alphabetic order by recipient's last name.
- By Recipient ID.* Claims will be reported in numeric order by recipient's Medicaid ID number.
- 24 Indicate which services under which waivers you are applying for, and which standards you meet. Include with the application the documentation that the specific requirement is met.
- 25 **Signature.** Original signature required. Applications not properly signed will be returned.
- 26 **Date.** Enter date application is signed.

Iowa Department of Human Services

Medicaid HCBS Waiver Provider Application

When completed send to:
 ACS, Inc.
 Provider Enrollment
 P.O. Box 14422
 Des Moines, IA 50306-3422
Tel. (800) 338-7909

**Make sure you have read
 the instructions before
 completing this form!**

For questions, contact:
 HCBS Waiver Program
 Tel:
(515) 281-8061
 email:
akryuch@dhs.state.ia.us

Individual applicants applying for Consumer-Directed Attendant Care (CDAC), please, complete sections I and II.

~~Agencies applying for services please complete sections I and III~~

I. GENERAL SECTION

1. Current Provider Number (if already an HCBS provider)										0						
2. Provider Name																
3. Street Address												4. Suite or Apt. #				
5. City												6. State				
7. Zip Code (9-digit if known)																
8. County Name														9. County		
10. Telephone Number								()				
11. Fax Number								()				
12. E-mail Address (please, print)																
13. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE CANNOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS SIGNED!)												/			/	
14. Indicate the HCBS waiver program(s) for which application is being made																
<input type="checkbox"/> Ill & Handicapped (IH) <input type="checkbox"/> AIDS/HIV (AH) <input type="checkbox"/> Elderly (E)				<input type="checkbox"/> Mentally Retarded (MR) <input type="checkbox"/> Brain Injury (BI)* <input type="checkbox"/> Physical Disability (PD)				* – Those wishing to provide services under the Brain Injury waiver need to submit documentation indicating training or experience with persons with brain injury. Training classes are available through DHS. To receive training call (515) 281-8061.								

If you are an individual applicant applying for Consumer-Directed Attendant Care (CDAC), please, proceed to section II. Otherwise, proceed to section III.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

15. Social Security Number				-			-			
----------------------------	--	--	--	---	--	--	---	--	--	--

16. Indicate that you are applying for Consumer-Directed Attendant Care (CDAC)

Service and Requirements	Circle the waiver(s) for which you are applying
<input type="checkbox"/> 04 – Consumer Directed Attendant Care (CDAC)	
<input type="checkbox"/> 21 – Individual Applicant must submit a photocopy of birth certificate <u>OR</u> driver's license. Must show date of birth. →	IH AH E MR BI PD

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- ◆ I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- ◆ I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- ◆ I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- ◆ I understand that I must describe in detail my training and/or experience on form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and this will be reviewed and approved by the case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- ◆ I hereby confirm that all information provided by me on this form is true and correct to my best knowledge.

17 Signature

18. Date			/			/			
----------	--	--	---	--	--	---	--	--	--

Note: Once the application process has been completed, you will receive notification from ACS.

III. AGENCIES APPLYING FOR WAIVER SERVICES

15. Tax ID Number			-						
16. Contact Person	<input type="checkbox"/>	<input type="checkbox"/>							
17. Do you have any <u>HCBS waiver-related</u> provider numbers besides the one shown in question 1? If "yes", please, list them here								<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Has there been any disciplinary action against you by any licensing boards or certification body?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Have you ever been excluded from participation in the Medicare Program? If "yes," please explain on a separate piece of paper								<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Type of Practice Code (Please Check One)									
<input type="checkbox"/> 01 – Individual Applicant	<input type="checkbox"/> 05 – Government Owned	<input type="checkbox"/> 09 – Group							
<input type="checkbox"/> 02 – Partnership	<input type="checkbox"/> 06 – Not for Profit	<input type="checkbox"/> 10 – University Affiliated Clinic							
<input type="checkbox"/> 03 – Corporation/Profit Organization	<input type="checkbox"/> 07 – Private Owner								
<input type="checkbox"/> 04 – Hospital Based	<input type="checkbox"/> 08 – HMO								
21. Type of Ownership Code (Please Check One)									
<input type="checkbox"/> 01 – Individual Applicant	<input type="checkbox"/> 04 – Partner	<input type="checkbox"/> 07 – Nonprofit Organization							
<input type="checkbox"/> 02 – Board Member/Commissioner	<input type="checkbox"/> 05 – Corporation	<input type="checkbox"/> 08 – Trust							
<input type="checkbox"/> 03 – Sole Ownership	<input type="checkbox"/> 06 – Government Entity								

Remittance Statement Control – Please read instructions on first page before completing!

22. Claims in Process Information (Check one) <input type="checkbox"/> Y = Print suspended claims only once <input type="checkbox"/> A = Print all suspended claims (until paid or denied) <input type="checkbox"/> N = Do not print suspended claims	23. Remittance Sequence (Check one) <input type="checkbox"/> 1 = By recipient name <input type="checkbox"/> 2 = By recipient ID
---	--

24. Indicate the service(s) for which you are applying and attach proof that the requirement is met.

Service and Requirements	Circle the waiver(s) for which you are applying
01 – Adult Day Care	
<input type="checkbox"/> 01 – CARF Accredited	→ IH AH E BI
<input type="checkbox"/> 02 – Contract with Veterans Administration	→ IH AH E BI
<input type="checkbox"/> 03 – JCAHCO Accredited	→ IH AH E BI
<input type="checkbox"/> 57 – Contract with Department of Elder Affairs	→ IH AH E BI
<input type="checkbox"/> 58 – Letter of certification from Department of Elder Affairs stating agency meets IDEA-IAC 321 Chapter 24 standards	→ IH AH E BI
<input type="checkbox"/> 59 – Contract with Area Agency on Aging	→ IH AH E BI
<input type="checkbox"/> 60 – Letter of certification from Area Agency on Aging stating agency meets IDEA-IAC 321 Chapter 24 standards	→ IH AH E BI
02 – Assistive Devices	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→ E
<input type="checkbox"/> 59 – Contract with Area Agency on Aging	→ E
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→ E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (Medicaid Provider # _____)	→ E

Service and Requirements	Circle the waiver(s) for which you are applying
<input type="checkbox"/> 25 – Behavioral Programming	
<input type="checkbox"/> 46 – Submit policies, procedures, and forms →	BI
<input type="checkbox"/> 26 – Case Management	
<input type="checkbox"/> 47 – Meets 441 IAC – Chapter 24 Case Management →	BI
<input type="checkbox"/> 03 – Chore	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231) →	E
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging →	E
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service →	E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 →	E
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	E
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____) →	E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa →	E
<input type="checkbox"/> 11 – Provider certified under the HCBS MR waiver →	E
<input type="checkbox"/> Consumer Directed Attendant Care (CDAC)	
<input type="checkbox"/> 31 – Assisted Living Provider	
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Elder Affairs →	E
<input type="checkbox"/> 29 – Agency, Hour	<input type="checkbox"/> 30 – Agency, Day
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____) →	IH AH E MR BI PD
<input type="checkbox"/> 12 – Home Care Agency with written certification from Department of Public Health stating that home care standards and requirements set forth in Department of Public Health rules 641 IAC 80.5(135)-80.7(135) are met →	IH AH E MR BI PD
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E MR BI PD
<input type="checkbox"/> 13 – Chore provider contracting with an Area Agency on Aging →	IH AH E MR BI PD
<input type="checkbox"/> 14 – Chore provider with letter of approval from an Area Agency on Aging stating that the organization is qualified to provide chore. →	IH AH E MR BI PD
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 →	IH AH E MR BI PD
<input type="checkbox"/> 15 – Provider enrolled under HCBS MR or BI Supported Community Living →	IH AH E MR BI PD
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Elder Affairs →	IH AH E MR BI PD
<input type="checkbox"/> 17 – Adult Day Care provider contracting with an Area Agency on Aging →	IH AH E MR BI PD
<input type="checkbox"/> 67 – Adult Day Care provider – CARF accredited →	IH AH E MR BI PD
<input type="checkbox"/> 68 – Adult Day Care provider – JCACHO accredited →	IH AH E MR BI PD
<input type="checkbox"/> 19 – Adult Day Care provider with contract with Veterans Administration →	IH AH E MR BI PD
<input type="checkbox"/> 63 – Adult Day Care provider with a letter of notification from Department of Elder Affairs stating the provider meets 321 IAC Chapter 25 →	IH AH E MR BI PD
<input type="checkbox"/> 64 – Adult Day Care provider with a letter of notification from an Area Agency on Aging stating the provider meets 321 IAC Chapter 25 →	IH AH E MR BI PD
<input type="checkbox"/> Counseling	
<input type="checkbox"/> 32 – Individual	<input type="checkbox"/> 33 – Group
<input type="checkbox"/> 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____) →	IH AH
<input type="checkbox"/> 23 – Hospice (Certificate of License or Medicare Provider # _____) →	IH AH
<input type="checkbox"/> 24 – Mental Health Service Provider (Certificate of Accreditation) →	IH AH

Service and Requirements	Circle the waiver(s) for which you are applying
34 – Family Counseling	
<input type="checkbox"/> 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____) →	BI
<input type="checkbox"/> 23 – Hospice (Certificate of License or Medicare Provider # _____) →	BI
<input type="checkbox"/> 24 – Mental Health Service Provider (Certificate of Accreditation) →	BI
<input type="checkbox"/> 48 – Qualified brain injury professionals as designated in 441 IAC 83.8(249A) →	BI
07 – Home Delivered Meals	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231) →	IH AH E
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging →	IH AH E
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service →	IH AH E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 →	IH AH E
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____) →	IH AH E
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E
<input type="checkbox"/> 26 – Hospital (Medicare Provider # _____) →	IH AH E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (Medicaid Provider # _____) →	IH AH E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa →	IH AH E
<input type="checkbox"/> 27 – Restaurant licensed and inspected under Iowa Code chapter 137B →	IH AH E
08 – Home Health Aide	
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E MR
09 – Homemaker	
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____) →	IH AH E
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E
10 – Home/Vehicle Modifications (HVM)	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231) →	IH E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 →	IH E
<input type="checkbox"/> 15 – Provider enrolled under HCBS MR or BI Supported Community Living →	IH E MR BI PD
<input type="checkbox"/> 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider →	IH E MR BI PD
<input type="checkbox"/> 39 – Community Business. Submit current proof of liability and workers compensation coverage →	IH E MR BI PD
Interim Medical Monitoring & Treatment (IMMT)	
35 – Home Health Agency – HHA Care	36 – Home Health Agency – RN Care
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH MR BI
37 – Group Care	
<input type="checkbox"/> 41 – Licensed child care center →	IH MR BI
<input type="checkbox"/> 42 – Registered group child care home →	IH MR BI
<input type="checkbox"/> 43 – Registered family child care home →	IH MR BI
38 – SCL	
<input type="checkbox"/> 15 – Provider certified under HCBS Supported Community Living →	IH MR BI


Service and Requirements	Circle the waiver(s) for which you are applying
<input type="checkbox"/> 11 – Mental Health Outreach	
<input type="checkbox"/> 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____) →	E
<input type="checkbox"/> 12 – Nursing	
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E MR
<input type="checkbox"/> 13 – Nutritional Counseling	
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 →	IH E
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH E
<input type="checkbox"/> 26 – Hospital (Medicare Provider # _____) →	IH E
<input type="checkbox"/> 28 – Licensed dietitian approved by an Area Agency on Aging →	IH E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa →	IH E
<input type="checkbox"/> 06 – Personal Emergency Response (PERS)	
<input type="checkbox"/> 39 – Initial Installation	<input type="checkbox"/> 40 – Monthly
<input type="checkbox"/> 25 – Send information pamphlet →	IH E MR BI PD
<input type="checkbox"/> 41 – Prevocational Services	
<input type="checkbox"/> 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers →	BI
<input type="checkbox"/> Respite	
<input type="checkbox"/> 42 – HHA – Specialized	<input type="checkbox"/> 43 – HHA – Basic Individual
<input type="checkbox"/> 44 – HHA – Group	
<input type="checkbox"/> 08 – Home Health Agency (Medicare Provider # _____) →	IH AH E MR BI
<input type="checkbox"/> 45 – Non-Facility Care – Specialized	<input type="checkbox"/> 46 – Non-Facility Care – Basic Individual
<input type="checkbox"/> 47 – Non-Facility Care – Group	
<input type="checkbox"/> 29 – Provider certified under HCBS MR Respite →	IH AH E BI
<input type="checkbox"/> 46 – Submit policies, procedures, and forms →	MR BI
<input type="checkbox"/> 48 – Home Care Agency – Specialized	<input type="checkbox"/> 49 – Home Care Agency – Basic Individual
<input type="checkbox"/> 50 – Home Care Agency – Group	
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____) →	IH AH E MR BI
<input type="checkbox"/> 51 – Facility Care	
<input type="checkbox"/> 26 – Hospital (Medicare Provider # _____) →	IH AH E MR BI
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa →	IH AH E MR BI
<input type="checkbox"/> 35 – ICF/MR (Medicaid Provider # _____) →	IH AH MR BI
<input type="checkbox"/> 44 – Licensed group living foster care facility →	IH AH MR BI
<input type="checkbox"/> 32 – Camp accredited by the American Camping Association →	IH AH E MR BI
<input type="checkbox"/> 30 – Adult Day Care Providers →	IH AH E MR BI
<input type="checkbox"/> 41 – Licensed child care center →	IH AH MR BI
<input type="checkbox"/> 50 – RCF/PMR →	IH AH MR BI
<input type="checkbox"/> 17 – Senior Companion	
<input type="checkbox"/> 37 – Designation by Corporation for National and Community Service →	E
<input type="checkbox"/> 19 – Specialized Medical Equipment	
<input type="checkbox"/> 06 – Medical equipment and supply dealers (Medicaid Provider # _____) →	BI PD
<input type="checkbox"/> 40 – Retail and wholesale businesses participating as providers in the Medicaid program (Medicaid Provider # _____) →	BI PD

Service and Requirements	Circle the waiver(s) for which you are applying
<input type="checkbox"/> Supported Community Living (SCL)	
<input type="checkbox"/> 53 – Daily	<input type="checkbox"/> 54 – Hourly
<input type="checkbox"/> 46 – Submit policies, procedures, and forms	→ MR BI
<input type="checkbox"/> 53 – Provider enrolled under HCBS MR Supported Community Living	→ BI
<input type="checkbox"/> 54 – Provider enrolled under HCBS BI Supported Community Living	→ MR
<input type="checkbox"/> Supported Community Living – 5 Persons (SCL-5)	
<input type="checkbox"/> 56 – Daily	<input type="checkbox"/> 57 – Hourly
<input type="checkbox"/> 51 – RCF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)"d"(1) b. Submit copy of 5 bed RCF/PMR licensure	→ MR
<input type="checkbox"/> Supported Community Living – 8 Persons (SCL-8)	
<input type="checkbox"/> 59 – Daily	<input type="checkbox"/> 60 – Hourly
<input type="checkbox"/> 52 – ICF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)"d"(1) b. Submit copy of 8 bed ICF/MR licensure	→ MR
<input type="checkbox"/> 61 – Supported Community Living – Residential-Based (SCL-RB)	
<input type="checkbox"/> 65 – Group Living Foster Care Facility: a. Submit copy of group living foster care licensure under IAC 441 Chapter 114 b. Submit plan to come into compliance with IAC 441 77.37(23)"e"(3)	→ MR
<input type="checkbox"/> 66 – Residential Facility for Mentally Retarded Children a. Submit copy of Residential Facility for Mentally Retarded Children under IAC 441 Chapter 116 licensure: b. Submit plan to come into compliance with IAC 441 77.37(23)"e"(3)	→ MR
<input type="checkbox"/> 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→ MR
<input type="checkbox"/> Supported Employment	
<input type="checkbox"/> 63 - Activities to Obtain a Job	<input type="checkbox"/> 64 - Job Coaching
<input type="checkbox"/> 65 - Personal Care	<input type="checkbox"/> 66 - Enclave
<input type="checkbox"/> 46 – Submit policies, procedures, and forms	→ MR BI
<input type="checkbox"/> 55 – Provider certified under HCBS MR Supported Employment	→ BI
<input type="checkbox"/> 56 – Provider certified under HCBS BI Supported Employment	→ MR
<input type="checkbox"/> Transportation	
<input type="checkbox"/> 67 – Regional Transit Authority	
<input type="checkbox"/> 38 – Regional Transit Agency recognized by Iowa Department of Transportation	→ E BI PD
<input type="checkbox"/> 68 – Area Agency on Aging	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→ E BI PD
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging	→ E BI PD
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→ E BI PD
<input type="checkbox"/> 69 – Mile	
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93	→ E BI PD
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa	→ E BI PD

24. Signature of authorized official

24. Date

Note: Once the application process has been completed, you will receive notification from ACS.

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C. Certification and Enrollment of New Providers

When your application is approved, HCBS specialists will recommend certification to the Bureau of Long Term Care. The Bureau of Long Term Care will send you form 470-3516, *Certificate for Certified Services*. An initial certification is effective for 270 days.

ACS will send you a:

- ◆ Letter with your provider number.
- ◆ Signed provider agreement, form 470-2965.
- ◆ Provider manual.


After the initial certification, deemed status is available for agencies accredited in good standing as a provider of a similar service by:

- ◆ The Council on Accreditation of Rehabilitation Facilities (CARF),
- ◆ The Council on Accreditation of Services for Families and Children (COA), or
- ◆ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- ◆ The Council on Quality and Leadership in Supports for People with Disabilities (the Council).

“Similar service” means the CARF-accredited, COA-accredited, JCAHO-accredited, or Council-accredited service is provided in the least restrictive environment, promotes independence, provides consumer choice, and includes all other service elements as described in the this manual for the specific service.

If you are seeking deemed status, submit copies of current CARF, COA, JCAHO, or Council accreditation and the evaluations which show the agency to be in good standing. “Good standing” means your accreditation is current and unconditional.

If you demonstrate substantial compliance with required standards at the time of the review and remain unconditionally accredited by CARF or The Council, deemed status for this service will continue for the next three-year period.

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Note: If deemed status has been granted due to CARF or Council accreditation, but upon a new CARF or Council survey, your agency is not recertified for two or three years (as applicable), your agency must notify the Department regarding your status. HCBS specialists may complete an on-site review for the agency to remain eligible for waiver certification.

D. Recertification

You must be recertified when your current certification ends (after 270 days, one year, or three years). You must demonstrate substantial continued compliance with standards for recertification to occur. The HCBS specialist initiates recertification.

The recertification procedures for supported community living, supported employment, and certified respite services are initiated:

- ◆ Before the expiration of the current certification and
- ◆ Following an on-site review or determination that the agency remains accredited by CARF or the Council.

1. Deemed Status Providers

If you are accredited for similar services, your certification continues as long as you maintain current accreditation as outlined in “deemed status.” Submit reports from the accrediting body to the HCBS specialist as documentation of continued accreditation. HCBS specialists may conduct an on-site review to evaluate your compliance with required standards.

2. Certified Providers

If you are certified without deemed status, specialists will conduct an on-site review before your current certification expires. These reviews are similar to those required for initial certification.

The HCBS specialists will look at consumer files, objectives, scope, organization, and effectiveness of the waiver program to ensure that the service has the greatest impact on consumers and provides opportunities to improve service outcomes. Specialists may conduct interviews with consumers.



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Following the review, HCBS specialists will give you a copy of the review report, noting service strengths and deficiencies. You must submit a provider acknowledgement identifying that you have received the review report and will actively work to correct the areas noted in the report.

HCBS specialists will hold an exit conference with you to share preliminary findings of the certification review. They will write a review report and send it to you within 30 calendar days unless you and the specialists mutually agree to extend that time frame.

Corrective action plans are required when the necessary criteria are not met. The plans may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

E. Changes


Notify the HCBS waiver office and the county of a decision to:

- ◆ Not renew enrollment.
- ◆ Withdraw from the provision of any waiver service.
- ◆ Add a new service under the waiver.

The notice must be in writing and must be received by the Division of Medical Services 30 days before the date of service or program termination.

F. Adding New Service for Existing Provider

To add a new MR waiver service when you are an existing MR waiver provider, a new application is required. Request an application from the Medicaid fiscal agent as identified in section I. A. **Provider Enrollment**, of this manual. Attach data necessary to qualify as a provider of that service.

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The Department of Human Services must approve the service before ACS adds that category of service to its file. No new provider number is issued. If you do not follow this process, your claims for this new service will be denied.

G. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new *Medicaid HCBS Waiver Provider Application*, form 470-2917.

Adding a satellite office does not require the completion of a new waiver provider application if the satellite office uses the main office's provider number for billing purposes. If you choose to have a separate provider number for the satellite office, you must file another waiver application.

II. STANDARDS FOR PROVIDERS OF CERTIFIED SERVICES

Providers are eligible to participate in the Medicaid program as approved MR waiver service providers based on the standards pertaining to the individual service.

You must have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. "Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

You must also have written policies and procedures and a staff-training program for the identification and reporting of child and dependent adult abuse to the Department.

You must have written procedures that provide for the establishment of an agreement between you and the consumer. The agreement must define the responsibilities of your agency and the consumer, the rights of the consumer, the services to be provided, all room and board and co-payment fees to be charged to the consumer and the sources of payment. These contracts must be reviewed at least annually.



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You must ensure the rights of persons applying for services. Consumers and their legal representatives have the right to appeal your application of policies or procedures, or any staff or contractual person's action which affects the consumer. Distribute the policies for consumer appeals and procedures to consumers.

If you store, handle, prescribe, dispense or administer prescription or over-the-counter medications, you must develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, these procedures shall be in accordance with Department of Inspections and Appeals rules for handling drugs in a residential care facility for the mentally retarded.

If you conduct research involving consumers, you must have written policies and procedures addressing the research. These policies and procedures shall ensure that rights of consumers and staff are protected.

In addition, supported community living and supported employment providers must meet the outcome-based standards set forth below. Respite providers must meet the organizational standards in Outcome 1.

Organizational outcome-based standards for HCBS MR providers are as follows:

Outcome 1.

- ◆ The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- ◆ The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.
- ◆ The organization establishes and maintains fiscal accountability.
- ◆ The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with consumers.



- ◆ The organization provides needed training and supports to its staff. This training includes at a minimum:
 - Consumer rights.
 - Confidentiality.
 - Provision of consumer medication.
 - Identification and reporting of child and dependent adult abuse.
 - Individual consumer support needs.
- ◆ The organization demonstrates methods of evaluation:
 - Past performance is reviewed.
 - Current functioning is evaluated.
 - Plans are made for the future based on the evaluation and review.
- ◆ Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action that affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- ◆ The provider shall have written policies and procedures and a staff-training program for the identification and reporting of child and dependent adult abuse to the Department of Human Services.
- ◆ The governing body has an active role in the administration of the agency.
- ◆ The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Outcome-based standards for **rights and dignity** are as follows:

- ◆ Outcome 2. Consumers are valued.
- ◆ Outcome 3. Consumers live in positive environments.
- ◆ Outcome 4. Consumers work in positive environments.
- ◆ Outcome 5. Consumers exercise their rights and responsibilities.
- ◆ Outcome 6. Consumers have privacy.
- ◆ Outcome 7. When there is a need, consumers have support to exercise and safeguard their rights.
- ◆ Outcome 8. Consumers decide which personal information is shared and with whom.



- ◆ Outcome 9. Consumers make informed choices about where they work.
- ◆ Outcome 10. Consumers make informed choices on how they spend their free time.
- ◆ Outcome 11. Consumers make informed choices about where and with whom they live.
- ◆ Outcome 12. Consumers choose their daily routine.
- ◆ Outcome 13. Consumers are a part of community life and perform varied social roles.
- ◆ Outcome 14. Consumers have a social network and varied relationships.
- ◆ Outcome 15. Consumers develop and accomplish personal goals.
- ◆ Outcome 16. Management of consumer's money is addressed on an individualized basis.
- ◆ Outcome 17. Consumers maintain good health.
- ◆ Outcome 18. The consumers' living environment is reasonably safe in the consumer's home and community.
- ◆ Outcome 19. The consumer's desire for intimacy is respected and supported.
- ◆ Outcome 20. Consumers have an impact on the services they receive.

A. Adult Day Care Providers

Adult day care providers shall hold a current certificate for adult day services issued by the Department of Inspections and Appeals and shall meet all current requirements for certification under 2003 Iowa Acts, House File 672. A certificate from DIA must be submitted with the application to be certified for waiver.

B. Consumer-Directed Attendant Care Providers

A public or private agency or an individual working independently as a provider of consumer-directed attendant care must be enrolled to provide waiver services.

The following providers may be enrolled to provide consumer-directed attendant care service:

- ◆ An individual who contracts with the consumer to provide attendant care service and who is:
 - At least 18 years of age.
 - Qualified by training or experience to carry out the consumer's plan of care pursuant to the Department-approved service plan.



- Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
- Not the recipient of respite services paid through HCBS on behalf of a consumer who receives HCBS.
- ◆ Home care providers that have a contract with the Iowa Department of Public Health or have written certification from the Department of Public Health stating they meet the home care standards and requirements set forth in Department of Public Health rules at 641--80.5(135) to 641--80.7(135).
- ◆ Home health agencies that are certified to participate in the Medicare program.
- ◆ Chore providers subcontracting with Area Agencies on Aging or with letters of approval from the Area Agencies on Aging stating that the organization is qualified to provide chore services.
- ◆ Community action agencies as designated in Iowa Code section 216A.93.
- ◆ Providers certified under an HCBS waiver for supported community living.
- ◆ Assisted living programs that are voluntarily accredited or certified by the Department of Elder Affairs.
- ◆ Adult day service providers that:
 - Meet the conditions of participation for adult day care providers under the HCBS ill and handicapped waiver, elderly waiver, AIDS/HIV waiver, or BI waiver; and
 - Have provided a point-in-time letter of notification from the Department of Elder Affairs or an Area Agency on Aging stating the provider also meets the requirements of Department of Elder Affairs rules for non-facility-based respite care in 321 Iowa Administrative Code Chapter 25.

The consumer, parent, guardian, or attorney-in-fact under a durable power of attorney shall be responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The Department of Human Services as the single state Medicaid agency has the same oversight responsibility for consumer-directed attendant care providers as it does for providers of any other home- and community-based waiver services.



Providers must demonstrate proficiency in delivery of the services included in a consumer's service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training.

All training and experience must be sufficient to protect the health, welfare and safety of the consumer. It is recommended that the provider receive certification of training for the following, which are available from the area community colleges:

- ◆ Transferring
- ◆ Catheter assistance
- ◆ Medication aide

After the interdisciplinary team and consumer determine the adequacy of the provider's training and experience, the consumer and provider shall complete form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*.

The county-designated service worker and the Department service worker must review and approve form 470-3372 before the provision of services. This form becomes an attachment to and part of the service plan.

Consumers will give direction and training for activities to maintain independence that are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372.

C. Home and Vehicle Modifications Providers

The following providers may provide home and vehicle modification:

- ◆ Providers certified to participate as supported community living service providers under the mental retardation or brain injury waiver.
- ◆ Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.
- ◆ Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.



D. Home Health Aide Providers

An agency must be a Medicare-certified home health provider to enroll as an HCBS MR home health aide service provider.

Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

E. Interim Medical Monitoring and Treatment (IMMT) Providers


The following providers may provide interim medical monitoring and treatment services:

- ◆ Licensed child care centers.
- ◆ Registered group child development homes.
- ◆ Home health agencies certified to participate in the Medicare program.
- ◆ Supported community living providers certified by the Department.

Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

- ◆ Be at least 18 years of age.
- ◆ Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.
- ◆ Not be a usual caregiver of the consumer.
- ◆ Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan.

Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed together with information concerning progress of treatment.

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F. Nursing Care Providers

Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

G. Personal Emergency-Response System Providers

Personal emergency response system service providers must meet the following standards:

- ◆ The agency must provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station.

The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.
- ◆ The agency, parent agency, institution, or corporation must have the necessary legal authority to operate in conformity with federal, state, and local laws and regulations.
- ◆ The provider must have a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority must employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
- ◆ The agency or institution must be in compliance with all legislation relating to prohibition of discriminatory practices.
- ◆ The provider must have written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.



H. Prevocational Services Providers

Providers of prevocational services must be accredited by one of the following to provide services under the MR waiver:

- ◆ The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- ◆ The Council on Quality and Leadership.

I. Respite Providers

Respite providers shall be:

- ◆ Home health agencies that are certified to participate in the Medicare program.
- ◆ Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- ◆ Group living foster care facilities for children licensed by the Department under 441 Iowa Administrative Code Chapters 112 and 114 to 116 and child care centers licensed under 441 Iowa Administrative Code Chapter 109.
- ◆ Camps certified by the American Camping Association.
- ◆ Home care agencies that meet the home care standards and requirements set forth in Department of Public Health rules 641--80.5(135) through 641--80.7(135).
- ◆ Adult day health service providers accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitative Facilities (CARF).
- ◆ Residential care facilities for persons with mental retardation (RCF/PMR) licensed by the Department of Inspection and Appeals.
- ◆ Agencies certified by the Department that meet the outcome standards in the introductory paragraphs to Section II.



Providers shall maintain the following information that shall be updated at least annually:

- ◆ The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
- ◆ An emergency medical care release.
- ◆ Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
- ◆ The consumer's medical issues, including allergies.
- ◆ The consumer's daily schedule which includes the consumer's preferences in activities or food or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- ◆ Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
- ◆ Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.



- ◆ Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
- ◆ Ensuring the safety and privacy of the individual. Policies shall at a minimum address fire, tornado, flood, and bomb threats.

Facilities providing respite shall not exceed the facility's licensed capacity and services shall be provided in locations consistent with licensure.

Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

J. Supported Community Living Providers

An agency is eligible to be certified as a supported community living service provider in the MR waiver program once the agency demonstrates compliance with the standards set forth in Medicaid rules. The Department does not recognize individuals as supported community living service providers.

Agency providers of supported community living services that meet the definition of foster care must also have a foster care license from the Department of Human Services. Agencies licensed for foster care may employ or contract with people meeting the definition of foster family homes to provide these services. These people must be licensed as foster family homes.

A maximum of three consumers receiving community-supported living alternative living arrangements or HCBS-MR services may reside in a living unit except as approved by the Department. The Department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.



Under previous legislation, the Department approved a limited number of five-bed living units converting from previous licensure as residential care facilities for persons with mental retardation.

Subject to federal approval, a residential program which serves not more than eight individuals and is licensed as an intermediate care facility for persons with mental retardation may surrender the facility license and continue to operate under the home- and community-based services waiver for persons with mental retardation.

The Department's Bureau of Long Term Care approves providers for conversion based on:

- ◆ The advisory committee's recommendation,
- ◆ The geographical distribution of providers, and
- ◆ The counties' written assurance that they will request sufficient slots for the consumers to be served and agree to provide necessary funding.

K. Supported Employment Providers

An agency is eligible to be certified as a supported employment service provider in the MR waiver program once the agency demonstrates compliance with the standards set forth in Medicaid rules.

The Department will contract only with public or private agencies to provide supported employment services. The Department does not recognize individuals as service providers under the supported employment program.

If the supported employment provider pays the consumer, the provider must have written policies that address the following:

- ◆ Consumer vacation, sick leave, and holiday compensation. Identify whether or not these benefits are provided. If these benefits are provided to the consumer, detail how the consumer may earn, accumulate, and use them.




- ◆ Consumer wages and pay schedules. Describe in what manner (e.g., hourly wages) and at what frequency (e.g., weekly) the consumer is paid.
- ◆ Worker's compensation insurance. Identify the worker's compensation insurer (company name) and the insurance certificate number. Identify the procedure by which the consumer may access worker's compensation insurance.
- ◆ Procedures for the determination and review of commensurate wages. Describe the manner in which consumer's wages are determined (e.g., piece rate, average hourly wage, etc.). Detail the frequency of wages reviews.
- ◆ Department of Labor requirements. Document your intent to comply with all pertinent Department of Labor rules and regulations governing wages (e.g., piece-rate, prevailing wage, etc.), the work environment (e.g., safety) and the consumer/employee (e.g., training, qualifications, etc.).

L. Transportation Providers

The following providers may provide transportation under the MR waiver:

- ◆ Accredited providers of home- and community-based services.
- ◆ Regional transit agencies as recognized by the Iowa Department of Transportation.
- ◆ Transportation providers that contract with county governments.
- ◆ Community action agencies as designated in Iowa Code Section 216A.93.
- ◆ Nursing facilities licensed under Iowa Code Chapter 135C.
- ◆ Area agencies on aging as designated in Department of Elder Affairs rule 321 Iowa Administrative Code 4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

Note: Accredited providers of home- and community-based services who are also providing supported community living would need to back the cost of transportation out of supported community living when providing both supported community living and transportation.

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III. HCBS MR WAIVER ELIGIBILITY

HCBS MR waiver programs are available to adults or children who meet income, resources, and service eligibility criteria.

Consumers apply to the local Department of Human Services (DHS) Income Maintenance Unit for the MR waiver program. The DHS income maintenance worker accepts the application and coordinates the Medicaid eligibility determination with the DHS service worker or Medicaid case manager, as applicable.

To be eligible for HCBS MR waiver services, a person must meet all of the following eligibility criteria. The person must:

- ◆ Be determined through the Department to have a diagnosis of mental retardation.
- ◆ Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.
- ◆ Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/MR. The Iowa Foundation for Medical Care is responsible for annual approval of the certification of the level of care, based on the data collected by the case manager and interdisciplinary team on a tool designated by the Department.
- ◆ Have service needs that can be met by this waiver program. At a minimum, after the initial access to the waiver:
 - An adult must receive one unit of either consumer-directed attendant care, supported community living, respite, or supported employment service per calendar quarter.
 - Children must receive one unit of either consumer-directed attendant care, interim medical monitoring and treatment services, respite service or supported community living service per calendar quarter.



- ◆ Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.
- ◆ Have a service plan completed annually and approved by the Department.
- ◆ Choose HCBS MR waiver services rather than ICF/MR services.
- ◆ Be assigned an HCBS MR payment slot.

To be eligible for supported employment services, a consumer must:


- ◆ Be at least 16 years old.
- ◆ Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.
- ◆ Not reside in a medical institution.

To be eligible for interim medical monitoring and treatment services, the consumer must be:

- ◆ Under the age of 21.
- ◆ Residing in the consumer's family home or foster family home.
- ◆ In need of interim medical monitoring and treatment as ordered by a physician.
- ◆ Currently receiving Medicaid home health agency services and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services.

The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.

If the applicant meets Medicaid income and resource eligibility standards, the DHS service worker or Medicaid case manager determines the applicant's HCBS waiver service eligibility. When a DHS service worker completes the service application, the DHS service worker continues to provide service until a Medicaid case manager is assigned to the consumer which must be the month HCBS services begin.

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The Medicaid case manager or DHS service worker convenes an interdisciplinary team meeting on behalf of the consumer to develop a single, integrated service plan to meet the consumer's needs for services.

A. Securing a Payment Slot

The county Department office contacts the Bureau of Long Term Care for state cases and children (or the central point of coordination administrator for the county of legal settlement for adults) to determine if a payment slot is available for all new applications for the HCBS MR program.

- ◆ For consumers not currently receiving Medicaid, the county Department office contacts the Bureau of Long Term Care or the county by the end of the second working day after receipt of a completed form 470-2927, *Health Services Application*, or after disability determination, whichever is later.
- ◆ For current Medicaid recipients, the county office contacts the Bureau of Long Term Care or the county by the end of the second working day after receipt of a signed and dated form 470-0659, *Home- and Community-Based Services Assessment or Reassessment*.

When a payment slot is available, the county or the Bureau assigns the slot to the applicant. Once assigned, the consumer and SW/CM arrange services, unless the consumer is determined ineligible for the program.

When there is no available slot, the Department will reject the application, but the person's name is maintained on the applicable county or state waiting list. The Bureau of Long Term Care or county will enter the applicant on a waiting list on the third day after the receipt of the completed form 470-0442 or 470-0660, according to the following:

- ◆ Applicants not currently eligible for Medicaid are entered on the waiting list on the basis of the date a completed form 470-2927 is date-stamped in the county Department office.



- ◆ Consumers currently eligible for Medicaid are added to the waiting list on the basis of the date the consumer requests HCBS MR program services, as documented by the date of the consumer's signature on form 470-0659.
- ◆ If more than one application is received at one time, applicants are entered on the waiting list on the basis of their month of birth, January being month one and the lowest number.

As slots become available, persons are selected from the waiting list to maintain the number of approved persons on the program, based on their order on the waiting list.

The county central point of coordination administrator for adults and the Bureau of Long Term Care for children and state cases will contact the county Department of Human services office when a slot becomes available. The county DHS worker contacts the applicant regarding the availability of a slot.

B. Service Planning

Persons receiving MR waiver services must also receive Medicaid case management services.

The consumer shall have a service plan approved by the Department which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter.

At initial enrollment the service worker, Department QMRP case manager paid by the county without Medicaid funds, or Medicaid case manager shall

- ◆ Establish the interdisciplinary team for the consumer, and
- ◆ With the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.



The Medicaid case manager shall complete an annual review thereafter.

In addition to the service plan, each service provider should document the activities associated with implementing the goals identified in the service plan.

The following criteria are used for the initial and ongoing assessments:


- ◆ Consumers aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- ◆ Service plans must be developed or reviewed, to reflect use of all appropriate nonwaiver services, so as not to replace or duplicate services.

1. Interdisciplinary Team

An interdisciplinary team must include the consumer and the case manager or service worker. Other persons on the team may be:

- ◆ The parents when the consumer is a minor.
- ◆ The consumer's legally authorized representative.
- ◆ The consumer's family, unless the family's participation is limited by court order or is contrary to the wishes of the adult consumer who has not been legally determined to be unable to make decisions independently.
- ◆ All current service providers.
- ◆ Other persons whose appropriateness may be identified through the initial intake or current review.
- ◆ Persons identified by the consumer or family, provided the family's wishes are not in conflict with the desires of the consumer.
- ◆ The central point of coordination for that county.

The team shall be convened to revise the service plan at least annually or whenever there is a significant change in the items addressed in it.


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2. Service Plan

The service plan is available to the consumer and all providers of services in accordance with statutes and regulations on confidentiality. The service plan must be free of professional jargon and be in language that is understandable and usable for the consumer and lay persons involved in its development and implementation. The service plan shall include the following:

- ◆ Consumer participation in payment for services, if any.
- ◆ A listing of all services both waiver and non waiver received by a consumer at the time of waiver program enrollment, to assist in evaluating the program.
- ◆ The name of the service provider responsible for providing the service.
- ◆ The service funding source.
- ◆ The amount of units and dollars of the service to be received by the consumer.
- ◆ The dates of services to be provided.
- ◆ For supported community living consumers, identification of:
 - The consumer's living environment at the time of waiver enrollment.
 - The number of other waiver consumers who will live with the consumer.
 - The number of hours per day of on-site staff supervision needed by the consumer.
- ◆ An identification and justification of any restriction of a consumer's rights including, but not limited to, maintenance of personal funds and self-administration of medications.

The case manager's or service worker's role is to be limited and facilitative in nature. It must consist of consumer referral to and contact with the appropriate service providers.

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C. Adverse Service Actions


This section contains the conditions that will result in:

- ◆ The denial of a consumer's application for waiver services,
- ◆ Reduction of the amount of waiver services provided, or
- ◆ Termination of waiver eligibility.

1. Denial of Application

The Department shall deny an application for services when it determines that:

- ◆ The consumer is not eligible for the services.
- ◆ Service needs exceed the service unit or reimbursement maximums.
- ◆ Service needs are not met by the services provided.
- ◆ Needed services are not available or received from qualifying providers.
- ◆ The HCBS MR service is not identified in the consumer's service plan.
- ◆ There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- ◆ The Department has not received required documents for the consumer.

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2. Reduction of Service

The Department may reduce a particular MR waiver service when it determines either of the following:

- ◆ Continued provision of service at its current level is not necessary. The Department must determine the level to which the service may be reduced without jeopardizing the consumer's continued progress toward achieving or maintaining the goal.
- ◆ Another community resource is available to provide the same or similar service to the consumer at no financial cost to the consumer, that will meet the consumer's needs.

3. Termination of Service

A particular service may be terminated when the Department determines that:

- ◆ The consumer's income or resources exceed the financial guidelines.
- ◆ Another community resource is available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- ◆ The consumer refuses to allow documentation of eligibility as to need, income, and resources.
- ◆ Needed services are not available or received from qualifying providers.
- ◆ The HCBS MR service is not identified in the consumer's annual service plan.
- ◆ The consumer's service needs are not met by the services provided.
- ◆ Needed services exceed the service unit or reimbursement maximums.
- ◆ The Department has not received required documents for the consumer.
- ◆ The consumer receives services from other Medicaid waiver programs.
- ◆ The consumer or legal representative through the interdisciplinary process requests termination from services.



IV. COVERED SERVICES

All services are provided to eligible consumers according to the individualized consumer need as identified in the service plan. Prior to service provision, you must obtain documentation of services, units, rates and time period authorized. The documentation should include the following:

- ◆ A copy of the Notice of Decision
- ◆ A copy of the Service Plan

The following sections list the general exclusion and limitations of waiver services, then detail the coverage requirements for each specific service.

A. Exclusions

1. Services Otherwise Available

Consumers may use services available under the regular State Medicaid Plan in addition to using the waiver services. When the same or similar service is available from an alternate source free of charge, the consumer must use that service before using the waiver services.

Home health aide and nursing care services are available to persons aged 20 or under waiver when the need for home health aide service exceeds the service available through regular Medicaid such as the Care for Kids (EPSDT).

Nursing and home health aide services for persons aged 21 and over may be reimbursed through the waiver only after the regular State Medicaid Plan or alternate-source reimbursement limits are met.

Consumers must obtain durable adaptive equipment available under the State Medicaid program, if applicable, before accessing the waiver's home and vehicle modification service.



2. Duplicate Services

A person may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS ill and handicapped waiver may not be enrolled in the HCBS MR waiver at the same time.

Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility).

Services may not be simultaneously reimbursed for the same time period. For example, only one provider may be reimbursed for one service during a specified hour, even if two providers arrive at the consumer's home at the same time to provide different services.

3. Services Provided Before Eligibility Determination

Before the Department will reimburse you for HCBS MR waiver services the following conditions must be met:

- ◆ You must be an enrolled Medicaid provider and,
- ◆ The consumer must have received both service and financial eligibility approval.

B. Adult Day Care

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Components of this service are as follows or as indicted in the Iowa Department of Elder Affairs *Annual Service and Fiscal Reporting Manual*.

- ◆ Medical emergency services. Instructions for dealing with medical emergency situations shall be established in writing. The instructions shall include the name and telephone number of a physician on call, written arrangements with a nearby hospital for inpatient and emergency room service, and provisions for ambulance transportation.



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- ◆ Rehabilitative services. Rehabilitative services shall include physical therapy, occupational therapy, recreational therapy, and speech therapy services which are provided by the day care center directly or indirectly through arrangements with qualified outside sources and which are designed to improve or maintain ability for the client's independent functioning.
- ◆ Personal care services. Personal care services shall include assistance with daily activities and training for independent daily living, such as walking, eating, toileting, grooming; and counseling in personal hygiene.
- ◆ Nutrition services. The day care center shall provide or make adequate arrangements for a minimum of one meal per day that is of suitable quality and quantity as to supply at least one-third of the daily nutritional requirement. Special diets and supplemental feeding shall be available if the client's needs so warrant.
- ◆ Social work services. The day care center shall provide or arrange for social services designed to promote preservation and restoration of the client's physical and mental health. A plan for the preservation and restoration is recorded in the client's record and is periodically evaluated in conjunction with the client's total plan of care. At a minimum, the following social services shall be available:
 - Completion of required social history information.
 - Information and referral services.
 - Individual and family counseling.
 - Assessment services in order to determine appropriateness of referrals for adult day care and to contribute to formulation of a plan of care.
 - Consistent participation with the day care team in the formulation, implementation, and evaluation of the client's overall plan at the daycare center.
 - Participation in the discharge planning and follow-u of clients.
 - Provision of in-service training to day care staff.



- ◆ Patient activities services. A plan for independent and group activities shall be developed for each participant in accordance with needs and interests. The plan is incorporated in the overall plan of care and is reviewed, with the client participating, at least quarterly and altered as needed.

Clients shall be encouraged, but not forced, to participate in planned activities appropriate to their individual needs. The facility shall provide adequate indoor and outdoor space and sufficient equipment and materials to support independent and group activities.

- ◆ Transportation services. The day care center shall provide or arrange for transportation for clients to and from their homes and to other community facilities utilized in implementing the client's plan of day care.

A unit of service is an extended day (8 to 12 hours), a full day (4 to 8 hours), or a half day (1 to 4 hours).


C. Consumer-Directed Attendant Care

Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks that the consumer would typically do independently if the consumer were otherwise able.

Consumers who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that CDAC is an appropriate service shall have CDAC included in their service plan.

Consumer-directed attendant care may not be simultaneously reimbursed with any other HCBS waiver services.

The consumer, parent, guardian, or attorney in-fact under a durable power of attorney for health care determines the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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If the consumer has a guardian or attorney in fact under a durable power of attorney for health care:

- ◆ The care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.
- ◆ The guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

The consumer, parent, guardian, or the attorney in fact under a durable power of attorney for health care must complete and sign form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when consumer-directed attendant care is part of the consumer's individualized service plan. A copy of the completed agreement must be provided to the service worker or case manager before services begin.

The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

It is recommended that provisions be made for alternate service providers to supplement service provision for emergencies that may arise. These alternate providers should be enrolled and designated in the service plan. This will allow the alternate service providers to assume the attendant care service provision immediately whenever necessary.

Each provider that is providing the consumer directed attendant care service must complete and sign a separate *Consumer Directed Attendant Care Agreement*.

Children under the age of 18 must have a parent or guardian present during the service provision.

A unit of service is 1 hour (up to 7 hours), or one 8- to 24-hour day provided by an individual or an agency. Bill each service in whole units.



1. Non-Skilled Covered Services

All consumer-directed attendant care services are supportive. The service activities may include helping the consumer with any of the following non-skilled service activities:

- ◆ Dressing.
- ◆ Bath, shampoo, hygiene and grooming.
- ◆ Access to and from bed or wheelchair, transferring, ambulation and mobility in general.
- ◆ Toilet assistance, including bowel, bladder and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter.
- ◆ Meal preparation, cooking, eating and feeding assistance, but not the actual cost of meals.
- ◆ Housekeeping services that are essential to the consumer's health care at home.
- ◆ Medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider, except for antihypertensives, digitalis preparation, mood altering or psychotropic drugs, or narcotics.
- ◆ Minor wound care that does not require skilled nursing care.
- ◆ Assistance needed to go to, or return from, a place of employment, and assistance with job-related tasks while the consumer is on the job-site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included.
- ◆ Cognitive assistance with tasks such as handling money and scheduling.
- ◆ Fostering communication through interpreting and reading services, as well as assistance in the use of assistive devices for communication.
- ◆ Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation for the consumer or the provider.



The service activities may not include parenting or child care for or on behalf of the consumer. The consumer-directed attendant care payment does not include the costs of room and board or the cost of transportation.

When a consumer has a consumer-directed attendant care service, the consumer-directed attendant care provider cannot receive respite services. An alternative consumer-directed attendant care provider may be used to provide the consumer-directed attendant care services.

2. Skilled Services Covered

The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated.

- ◆ Tube feedings of consumers unable to eat solid foods.
- ◆ Assistance with intravenous therapy which is administered by a registered nurse.
- ◆ Parenteral injections required more than once a week.
- ◆ Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- ◆ Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- ◆ Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- ◆ Rehabilitation services, including, but not limited to, bowel and bladder training, range-of-motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- ◆ Colostomy care.



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- ◆ Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.
- ◆ Post-surgical nurse-delegated activities under the supervision of the licensed nurse.
- ◆ Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- ◆ Preparing and monitoring response to therapeutic diets.
- ◆ Recording and reporting of changes in vital signs to the nurse or therapist.

The licensed nurse or therapist must ensure appropriate assessment, planning implementation and evaluation. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

3. Services Provided by Assisted Living Program

When consumer-directed attendant care is provided by an assisted living program, please note the following:

- ◆ The service worker or case manager should be aware of and have knowledge of the specific services included in the assisted living program contract to ensure that:
 - Assisted living program services are not duplicative of consumer-directed attendant care services.
 - Consumer's needs are being addressed.
 - Consumer's unmet needs are included in the care plan.



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- ◆ Consumer-directed attendant care payment does not include cost of room and board.
- ◆ Each consumer must be determined by IFMC to meet ICF/MR level of care.
- ◆ The consumer-directed attendant care fee is calculated based on the needs of the consumer and may differ from individual to individual.
- ◆ A consumer has the right to choose another provider of waiver services when living in an assisted living facility.

4. Fascimile of Form 470-3372

See the following pages for a fascimile of form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*.

HCBS CONSUMER-DIRECTED ATTENDANT CARE AGREEMENT

This is an agreement between a consumer of services under a Medicaid home- and community-based services waiver and the provider of consumer-directed attendant care.

Name of Consumer	Name of Provider
------------------	------------------

The Iowa Medicaid Program will reimburse services provided under this agreement when consumer-directed attendant care is part of the consumer's case plan and the social worker or case manager has determined that the prior training and experience of the provider are sufficient to meet the consumer's needs noted in this agreement. However, the consumer agrees not to hold the social worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The Medicaid agency is responsible to insure the health and welfare of the consumer.

Instructions:

The consumer or the consumer's guardian completes this form by entering information about how the provider will meet the standards and responsibilities and the agreed-upon rate of payment. The agreement must be completed and the copies distributed **before** the provider begins providing the service. Both the consumer and the provider must sign the form to signify that they agree to its provisions.

Photocopy of the completed form is given to the consumer, to the provider, and to the nurse or therapist supervising the provision of skilled services, if any.

The original is kept by the service worker or case manager and attached to the care plan.

Agreement:

The consumer and the provider agree that:

1. The provider, as an agency or self-employed contractor, is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department of Human Services to collect payments due as a result of the agreement between the consumer and the provider of consumer-directed attendant care.
2. This agreement will be reviewed at least annually and whenever there are significant changes in the consumer's situation.
3. This agreement will be renegotiated whenever there is a change: (a) of provider, (b) in the service components to be provided, or (c) in the description of provider activity.

RESPONSIBILITY:	HOW RESPONSIBILITY IS MET
Describe the plan for emergencies, including instruction in calling 911 first in all life-threatening situations.	
Describe in detail all of the provider's prior training and experience and how you evaluated it.	
Describe your provisions for managing the provider's services.	
Describe the performance standards for the provider.	
STANDARDS FOR THE PROVIDER:	CONFIRMATION OF STANDARD
1. Age (must be at least 18 years old)	
2. Social Security number:	
3. Evidence of basic math, reading, and writing skills (e.g. high school diploma, GED, etc.):	
4. Skills possessed as necessary to perform the attendant care components specified in this agreement:	
5. Evidence of the capability to perform the health maintenance activities specified in this agreement (experience, training, or statement of willingness to receive training before providing care)	
6. Insurance or bond for the activities provided upon consumer request.	<input type="checkbox"/> Insurance or bonding company: _____ Policy limit: \$ _____ Policy number: _____ <input type="checkbox"/> Requirement is waived:

Describe the components of care to be provided. Enter “Not Applicable” (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

NON-SKILLED SERVICE COMPONENTS	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Dressing.				
Bath, shampoo, hygiene, and grooming.				
Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. (Certification of training which includes demonstration of competence for transferring is available. See Note below.)				
Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter. (Certification of training which includes demonstration of competence for catheter assistance is available. See Note below.)				
Meal preparation, cooking, eating and feeding assistance (but not the cost of meals themselves).				
Housekeeping services which are essential to the consumer's health care at home.				

Note: Certification is available through the community colleges. There is no funding available through the waivers to cover this training cost.

NON-SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Medications ordinarily self-administered, including those ordered by a physician or other qualified health care providers which are not antihypertensives, digitalis preparations, mood altering, or psychotropic drugs or narcotics. (A medication aide course is available through the area community colleges.)				
Minor wound care which does not require skilled nursing care.				
Assistance needed to go to or return from a place of employment but not assistance to the consumer while the consumer is on the job site.				
Cognitive assistance with money handling and scheduling tasks.				
Fostering communication through interpreting and reading services, as well as assistive devices for communication.				
Assisting or accompanying the consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation.				

Service activities include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The cost of this supervision shall be paid from private insurance and other third party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program. The nurse or therapist must retain accountability for actions that are delegated and ensure appropriate assessment, planning, implementation, and evaluation.

The nurse or therapist shall make on-site supervisory visits every two weeks, with the provider present and document to this record. This nurse or therapist agrees to supervise these service components delivered by this provider:

Name and telephone number of supervising nurse or therapist:

Describe the components of skilled care to be provided. Enter “Not Applicable” (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

SKILLED SERVICE COMPONENTS	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Tube feedings of consumers unable to eat solid foods.				
Assistance with intravenous therapy administered by a licensed nurse.				
Parenteral injections required more than once a week.				
Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.				
Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.				
Rehabilitation services includes bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.				
Colostomy care.				
Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions).				
Postsurgical nurse delegated activities under the supervision of the licensed nurse.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g. hypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. A medication aid course is available through the area community colleges.				
Preparing and monitoring response to therapeutic diets.				
Recording and reporting of changes in vital signs to the nurse or therapist.				

The basis of reimbursement is the fee agreed upon between the consumer and the provider, within the upper limits allowed in the program and as established in the case plan or individual comprehensive plan (ICP). The agreed upon reimbursement rate to the provider is as follows (*complete one line only*):

HCPSC Code	Provider Type	Fee per Unit	Maximum Units	Upper Limit
W1265	Agency provider not an assisted living provider	\$_____ per hour, up to	_____ hours	\$18.49 per hour (1-7 hrs)
W1266	Agency provider not an assisted living provider	\$_____ per day, up to	_____ days	\$106.82 per day (8-24 hrs)
W1267	Individual provider	\$_____ per hour, up to	_____ hours	\$12.33 per hour (1-7 hrs)
W1268	Individual provider	\$_____ per day, up to	_____ days	\$71.90 per day (8-24 hrs)
W2517	Assisted living provider	\$_____ per month	1 month	\$1,052 per month, not to exceed \$34.60 per day

Consumer Signature	Date
--------------------	------

I agree to the services written in this form and:

- ◆ To submit to a criminal records check.
- ◆ That my protective services records may be checked for reported or confirmed abuse.
- ◆ To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this agreement by any and all persons.


_____ Provider Signature

_____ Date

ADDITIONAL INFORMATION ON BILLING:

Each service must be billed in whole units. Submit billings for all consumer-directed attendant care to ACS (the Medicaid fiscal agent) on form 470-2486, *Claim for Targeted Medical Care*. Both the consumer and the provider must sign and date the *Claim for Targeted Medical Care*. Obtain copies of this form from ACS, Provider Relations, at 1-800-338-7909.

Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for an entire month's service by the tenth of the month following the month of service. **EXAMPLE:** Ten hours of consumer-directed attendant care service was provided during the month of June. The claim for June's service should be submitted by the tenth day of July.

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D. Home and Vehicle Modifications

Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle are excluded except as specifically included below. Examples include furnaces, fencing, roof repair, or adding square footage to the residence. Repairs are also excluded.

Only the following modifications are covered:

- ◆ Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves and ovens.
- ◆ Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- ◆ Grab bars and handrails.
- ◆ Turnaround space adaptations.
- ◆ Ramps, lifts, and door, hall and window widening.
- ◆ Fire safety alarm equipment specific for disability.
- ◆ Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.
- ◆ Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- ◆ Keyless entry systems.
- ◆ Automatic opening device for home or vehicle door.
- ◆ Special door and window locks.
- ◆ Specialized doorknobs and handles.



- ◆ Plexiglas replacement for glass windows.
- ◆ Modification of existing stairs to widen, lower, raise or enclose open stairs.
- ◆ Motion detectors.
- ◆ Low-pile carpeting or slip-resistant flooring.
- ◆ Telecommunications device for the deaf.
- ◆ Exterior hard-surface pathways.
- ◆ New door opening.
- ◆ Pocket doors.
- ◆ Installation or relocation of controls, outlets, switches.
- ◆ Air conditioning and air filtering if medically necessary.
- ◆ Heightening of existing garage door opening to accommodate modified van.
- ◆ Bath chairs.

A unit of service is the completion of needed modifications or adaptations.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

Services shall be performed following Department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer. The contract shall include, at a minimum:

- ◆ The work to be performed.
- ◆ Cost.
- ◆ Time frame for work completion.
- ◆ Assurance of liability and workers' compensation coverage.

Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.




E. Home Health Aide Services

Home health aide services are unskilled medical services that provide direct personal care. This service may include:

- ◆ Range of motion exercises
- ◆ Application of medicinal skin crème
- ◆ Pediculosis shampooing
- ◆ Observation and reporting of physical or emotional needs
- ◆ Assistance with bathing, shampoo, and oral hygiene
- ◆ Assistance with toileting
- ◆ Assistance with ambulation
- ◆ Helping consumers in and out of bed
- ◆ Reestablishing activities of daily living
- ◆ Assisting with oral medications ordinarily self administered and ordered by a physician
- ◆ Performing incidental household services which are essential to the consumer's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service

Regular Medicaid provides for coverage of home health aide services on an intermittent basis for children and adults. Home health aide services are available to Medicaid eligible persons under age 21 through regular Medicaid, through Care for Kids (EPSDT) private duty nursing and personal care services.

Waiver home health aide services must exceed those activities provided under supported community living. Instruction, supervision, support, or assistance in personal hygiene, bathing, and daily living are activities provided under supported community living. Services may not duplicate any regular Medicaid or waiver services -provided under the state plan.

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Services are to be provided in the home. A unit of service is one hour.

Reimbursement is based on the provider's Medicare rate converted to an hour. A maximum of 14 hours per week is covered under the waiver.

F. Interim Medical Monitoring and Treatment (IMMT)

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting.

Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

- ◆ Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.
- ◆ Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker.

Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.
- ◆ Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services due to these circumstances are limited to a maximum 30 days.
- ◆ Search for employment.
 - Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.
 - Interim medical monitoring and treatment services may be provided only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the Department service worker or targeted case manager.
 - Documentation of job search contacts shall be furnished to the Department service worker or targeted case manager.



Interim medical monitoring and treatment services are available to consumers who are accessing the maximum hours available through intermittent home health services or the EPSDT program.

Interim medical monitoring and treatment services shall:


- ◆ Provide experiences for each consumer's social, emotional, intellectual, and physical development.
- ◆ Include comprehensive developmental care and any special services for a consumer with special needs.
- ◆ Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

Services may include supervision during transportation to and from school if not available from other sources.

A unit of service is one hour.

The following limitations apply to interim medical monitoring and treatment services:

- ◆ A maximum of 12 one-hour units of service is available per day.
- ◆ Covered services do not include a complete nutritional regimen.
- ◆ Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.
- ◆ Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered child development home, in a licensed child care center, or during transportation to and from school.
- ◆ The staff-to-consumer ratio shall not be less than one to six.

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G. Nursing Services

Nursing care services are services provided by licensed agency nurses to consumers in their homes that are ordered by and included in the plan of treatment established by the physician.

The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the consumer and included in the Iowa Board of Nursing scope of practice guidelines.


Reimbursement is based on the provider's maximum Medicare rate converted to an hour. A unit of service is one hour. A maximum of 10 hours service per week is covered.

H. Personal Emergency Response Services

The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

- ◆ An in-home medical communications transceiver.
- ◆ A remote, portable activator.
- ◆ A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.
- ◆ Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

The service must be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. A maximum of the initial installation and 12 months of service are covered per state fiscal year.

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I. Respite Services

Respite care services are services provided to the consumer that give temporary relief to the usual caregivers and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

Respite care is not to be provided to persons during the hours in which the usual caregiver is employed, except when the provider is a camp.

Respite services provided by home health agencies, home care agencies, and other non-facility providers are divided into specialized respite, group respite, and basic individual respite, with separate rates of payment.

- ◆ "Specialized respite" means respite provided on a staff-to-consumer ratio of one-to-one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.
- ◆ "Group respite" is respite provided on a staff-to-consumer ratio of less than one-to-one.
- ◆ "Basic individual respite" means respite provided on a staff-to-consumer ratio of one-to-one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

Services provided outside the consumer's home is not reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite.

A unit of service is one hour for all respite services. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.



Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code Chapter 135C.

When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

J. Prevocational Service

Prevocational services are services aimed at preparing a consumer for paid or unpaid employment, but which are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

Prevocational services are intended to have a more generalized result, as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but more generalized habilitative goals. Services are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services which are otherwise available to the consumer through a state or local education agency or vocational rehabilitation services which are otherwise available through a program funded under the Rehabilitation Act of 1973.

When compensated, providers are paid at less than 50% of the minimum wage.

K. Supported Community Living Services

Supported community living services are provided by the service provider agency within the consumer's home and community. All supported community living services must be designed to be available to the consumer on an as-needed basis up to 24 hours per day.

These services must:

- ◆ Be provided in the least restrictive environment possible and must
- ◆ Reflect the consumer's choice of living arrangement and services.



A consumer may choose almost any living arrangement. A consumer may live alone, or with family, friends, other consumers or staff. A consumer may buy or rent a house, trailer, condominium, or an apartment. A consumer may live in an environment owned by the consumer, an agency, or someone else.

A unit of service is:

- ◆ One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's service identifies and reflects the need for this amount of supervision.
- ◆ One hour for other situations.

The maximum numbers of units available per consumer are as follows:

- ◆ 365 daily units per state fiscal year except a leap year, when 366 daily units are available.
- ◆ 5,110 hourly units per state fiscal year except a leap year, when 5,124 hourly units are available.


The service must be identified in the consumer's service plan.

1. Living Arrangements

Services may be provided to a child or an adult in a variety of community-based, integrated residential neighborhoods. Maintenance and room and board costs are not reimbursable.

Consumers may live within the home of their family or legal representatives or within other types of typical community living units. Group living units must be approved by the Department, as described in Section II. J, **Supported Community Living Providers**.

Living units must be located throughout the community with regard for community norms in geographical proximity of residences. No more than eight consumers shall reside in settings with a maximum of four living units. Larger settings require the majority of living units to be occupied by individuals who are not disabled.

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2. Service Components

Available components of supported community living service are personal and home skills training services, individual advocacy service, community skills training services, personal environment support services, transportation, and treatment services. These are defined as follows:

- ◆ Personal and home skill training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directness, and care of the immediate environment.
- ◆ Individual advocacy services are the act or process of representing a person's rights and interests in order to realize the rights to which the person is entitled and to remove barriers to meeting the person's needs.
- ◆ Community skills training services are activities which assist a person to develop or maintain skills which allow better participation in the community. Services must focus on the following areas as they are applicable to the person being served:

- Personal management skills training services are activities which assist a consumer to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills.

Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources (such as public transportation and libraries), and select foods at the grocery store.

- Socialization skills training services are activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
- Communication skills training services are activities which assist a consumer to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.



- ◆ Personal and environmental support services are activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.
- ◆ Transportation services are activities and expenditures designed to assist the consumer to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or a day program.
- ◆ Treatment services are activities designed to assist the consumer to maintain or improve physiological, emotional and behavioral functioning, and to prevent conditions that would present barriers to a consumer's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment:
 - Physiological treatment means activities, including medication regimens, designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. These activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the activity specified.
 - Psychotherapeutic treatment means activities provided to assist a consumer in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the consumer's functioning in response to the physical, emotional, and social environment.

L. Supported Employment Services

Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model.



Covered services address the disability-related challenges to securing and keeping a job. Covered services are divided into activities to obtain a job and support to maintain employment. Covered services provided to or on behalf of the consumer associated with obtaining competitive paid employment (activities to obtain a job) are the following:

- ◆ Initial vocational and educational assessment to develop interventions with the consumer or employer that affect work.
- ◆ Job development activities.
- ◆ On-site vocational assessment prior to employment.
- ◆ Disability-related support for vocational training or paid internships.
- ◆ Assistance in helping the consumer learn the skills necessary for job retention including skills to arrange and use supported employment transportation and job exploration.

All services provided to an individual for the purpose of obtaining employment during a 12-month period are one unit of service. **Exception:** An individual may receive more than one unit of service for obtaining competitive employment during a 12-month period only if the individual has been in competitive paid employment for a minimum of 30 consecutive days between units of service.

A unit of service is one job placement. A maximum of three units of service for obtaining employment is available per 12-month period.

Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment (supports to maintain employment) are the following:

- ◆ Individual work-related behavioral management.
- ◆ Job coaching.
- ◆ On-the-job or work-related crisis intervention.
- ◆ Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
- ◆ Consumer-directed attendant care services.



- ◆ Assistance with time management.
- ◆ Assistance with appropriate grooming.
- ◆ Employment-related supportive contacts.
- ◆ Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
- ◆ On-site vocational assessment after employment.
- ◆ Employer consultation.

Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

A unit of service is one hour. A maximum of 40 units may be received per week.

The following requirements apply to all supported employment services:

- ◆ Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.
- ◆ Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
- ◆ The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.



- ◆ All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
- ◆ Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.
- ◆ All services shall be identified in the consumer's service plan.

The following services are not covered:


- ◆ Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs, work activity programs or sheltered workshop programs.
- ◆ Supports for volunteer work or unpaid internships.
- ◆ Tuition for education or vocational training.
- ◆ Individual advocacy that is not consumer specific.

Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

M. Transportation

Transportation services may be provided for consumer to conduct business errands and essential shopping, to receive medical services not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation.

A unit of service is a mile. Transportation may not be reimbursed simultaneously with HCBS mental retardation waiver supported community living service.

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V. BASIS OF PAYMENT


The design of the cost principles, administrative procedures, and supporting reporting for HCBS MR waiver services reflects the Department's intent to establish rates for care based on "necessary and reasonable" costs of providing the services within the standards established.

Reimbursable costs must meet two tests:

- ◆ Necessary: Essential to the provision of home- and community-based MR waiver services and to the achievement of service requirements and outcomes.
- ◆ Reasonable: At levels considered appropriate for the provision of quality care in Iowa.

HCBS providers must submit a cost report for waiver services using form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*. All MR waiver providers of supported community living, supported employment, and home and vehicle modification services must also submit form 470-3449, *Supplemental Schedule*.

Providers reconciling respite services are not required to submit the HCBS Supplemental Schedule D-4 from form 470-3449.

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A Financial and Statistical Report for Purchase of Service Contracts is required for the following types of respite providers:

- ◆ Home health agencies providing group respite.
- ◆ Non-facility providers of specialized, basic individual, and group respite.
- ◆ Camps.
- ◆ Home care agencies providing specialized, basic individual, and group respite.

All financial and statistical reports must meet the specifications described in this section. You complete the form or have responsibility for its content, if it is prepared by someone outside your agency.


A. Maintenance and Retention of Financial and Statistical Records

The financial information included in forms 470-0664 and 470-3449 must be taken from your financial and statistical records and must be verifiable by qualified auditors. To provide the required cost data and not impair comparability, you must maintain financial and statistical records in a consistent manner from one period to another.

Maintain sufficient financial and statistical records to document the validity of reports you submit to the Department. This includes program and census data. Failure to maintain records to support your cost reports may result in termination of your HCBS certification.

These records include, but are not limited to:

- ◆ All canceled checks, deposit slips, and invoices (paid and unpaid).
- ◆ Audit reports (if any).
- ◆ Board of directors minutes (if applicable).
- ◆ Capital asset schedules.
- ◆ Documentation of units of services provided to consumers.
- ◆ General ledger reconciliation to financial and statistical report.

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- ◆ Loan agreements and other contracts.
- ◆ Payroll information.
- ◆ Reviewable, legible census reports.

Maintain these forms and all financial and statistical records to support them for a minimum of five years. Make these reports and records available to authorized representatives and agents of the Department and of the United States Department of Health and Human Services, upon request.

B. Submission of the Financial and Statistical Reports

Forms 470-0664 and 470-3449 are due in to the Department by September 30 of each year for reconciliation of respite rate reimbursement. You may obtain a 30-day extension for submitting the cost reports by submitting a letter to the Division of Medical services by September 30. No extensions will be granted beyond 30 days.

Failure to submit a report by September 30 or an extended deadline granted shall **reduce payment** to 76 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time **no** further payments will be made.


If you have multiple-program agencies, you must also submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

The Department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

Forward the original and one copy, both having original signatures of an officer of the facility, to:

Ryun, Givens, Wenthe & Co
1641 48th St, Suite 150
West Des Moines, Iowa 50266-6722

Also send a copy to the central point of coordination administrator in the county where your main office is located.

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After your initial HCBS certification, submit the following documents for rate determination when you make one of the following changes:

- ◆ Adding supported community living with an hourly rate:
 - Certification page from form 470-0664
 - Schedule D from form 470-0664
 - Supplemental Schedules D-1, D-2 and D-3 from form 470-3449
 - Hourly rate calculation sheet from form 470-3449
- ◆ Adding supported employment initial instructional activities on the job or enclave settings:
 - Certification page from form 470-0664
 - Schedule D from form 470-0664
 - Supplemental Schedules D-1, D-2, and D-3 from form 470-3449
 - Changing a site rate: Supplemental Schedule D-4 from form 470-3449

If you choose to leave the HCBS program or terminate a service, submit a final cost report within 60 days of termination for reconciliation of respite rates.

C. Facsimiles of Forms 470-0664 and 470-3449

See the following pages for samples of form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*, and form 470-3449, *Supplemental Schedule*.

Page 68 was intentionally left blank.

FINANCIAL AND STATISTICAL REPORT FOR PURCHASE OF SERVICE CONTRACTS

CERTIFICATION PAGE

Agency Name			IRS ID No.
Address			Contract No.
City		State	Zip Code
Period of Report:	From	To	Date of Fiscal Year End
Administrator Name			Telephone No.
Name of Person to Contact if Questions About the Report			Telephone No.

Does agency have an independent audit? ☐ Yes, for year ending ☐ No

Has a copy of the latest independent audit been submitted? ☐ Yes ☐ No

A. Type of Control: ☐ Government ☐ Nonprofit Organization ☐ Proprietary

B. Accounting Basis: ☐ Accrual ☐ Modified Cash ☐ Cash

C. Statistical Data for Period of Report:

1. Service code.
2. If subject to licensure, number of clients licensed for.
3. Number of units of service (licensed or staffed)
 - a. Type of unit (hourly, daily, etc.)
4. Total number of units of service provided.
5. Total number of units of service provided for:
 - a. DHS clients
 - b. Other clients
6. Percent of units provided to unit capacity (divide line 4 by line 3)
7. Are the rates received from non-DHS clients the same as, or more than, POS rates for the same service: Circle yes or no, for each service. If no, explain.:

Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No	No

D. Form of Certification by Officer or Administrator of Provider Agency:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared from the books and records of the facility in accordance with instructions contained in this report, and the allowable cost of care excludes expenses that were not necessary to provide this care.

Signature Officer or administrator of facility	
Title Officer or Administrator	Date

E. Statement of Preparer (if other than agency)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the agency for the period stated above.

Signature of Preparer	Date
-----------------------	------

F. Statement of Project Manager

I have reviewed this report prior to submitting it to the State (Department of Human Services, Bureau of Purchased Services, Purchase of Service Unit).

Signature of Project Manager	Date
------------------------------	------

Provider Agency		
Period of Report	From	To

SCHEDULE A: REVENUE REPORT

Revenues:	Total Revenue	Revenue for Schedule D Expense Deduction*
Fee for Service:		
Iowa State Department of Human Services	\$	
County Board of Supervisors		
Private Clients		
Department of Education (Voc Rehab) (service fees only)		
United Way (service fees only)		
Social Security, SSI, SSA		
Other		
Service, Reimbursement or Investment Income:		
Work Services Revenues	\$	\$
Food Reimbursement (DOE)		
Investment Income		
Other (attach schedule)		
Contributions: (Schedule must be attached:)		
United Way: Contributions not restricted or appropriated** to a specific individual	\$	
Restricted to specific individuals*		\$
Other: Contributions not restricted or appropriated** to a specific individual		
Restricted to specific individuals*		\$
Government Grants:		
Total Revenue	\$	*\$

* Income which must be deducted from total service expense on Schedule D.

** Agencies must have documentation or support which identifies purposes of contributions reported.

Provider Agency		
Period of Report	From	To

SCHEDULE B: STAFF NUMBERS AND WAGES

Job Classification and Title	Number of Staff			Gross Wages
	Full Time	Part Time	FTEs	
Administrative #2110 Job Title _____				

Administrative Total				
Professional #2120 Job Title _____				

Professional Total				
Direct Client Care #2130 Job Title _____				

Direct Client Care Total				
Clerical #2150 Job Title _____				

Clerical Total				
Other Staff Wages #2190 Job Title _____				

Other Staff Wages Total				
Total: ALL JOB CLASSIFICATIONS AND TITLES				

The maximum amount of wages chargeable to Purchase of Services for any one employee is \$40,000 annually. If an employee is paid in excess of \$40,000, the excess must be reported as "Other Nonreimbursable Costs" in column 3 of Schedule D or charged to Excluded Services (use column 5 of Schedule D).

Provider Agency		
Period of Report	From	To

SCHEDULE C: PROPERTY AND EQUIPMENT DEPRECIATION AND RELATED PARTY PROPERTY COSTS**PROVIDER -OWNED EQUIPMENT BUILDINGS**

Description:	Original Cost	Depreciation Recorded Prior Years	Method	Annual % Rate	Recorded Depreciation Expense	Straight-Line Depr.
Equipment:						
Building equipment						
Departmental equipment						
Other equipment _____						
Office furniture and fixtures						
Motor vehicles _____						
Total						
Buildings:						
Buildings						
Additions						
Leasehold improvements _____						
Other _____						
Total						
Total Equipment and Buildings						

RELATED PARTY PROPERTY COST

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook? ☐ Yes ☐ No

2. Schedule of Lessor's Costs:

If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property	_____
Property taxes	_____
Mortgage interest on property	_____
Insurance	_____
Other (describe)	_____
Total	_____

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		1	2	3	4	5	6	7	8	9	10
Acc No.	Account Title	Total Expense	Fund-Raising Cost	Other Nonreim-burseable Costs	Adjusted Cost: Col 1 minus Cols 2 & 3						Indirect Service Cost
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	TOTAL WAGES										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	TOTAL BENEFITS										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	TOTAL PAYROLL TAXES										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	TOTAL PROFESSIONAL FEES										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	TOTAL SUPPLIES										
2600	TELEPHONE AND TELEGRAPH										
2700	POSTAGE AND SHIPPING										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	TOTAL OCCUPANCY EXPENSE										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT**Direct Service Cost**

		11	12	13	14	15	16	17	18	19	20
Acc No.	Account Title										
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	TOTAL WAGES										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	TOTAL BENEFITS										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	TOTAL PAYROLL TAXES										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	TOTAL PROFESSIONAL FEES										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	TOTAL SUPPLIES										
2600	TELEPHONE AND TELEGRAPH										
2700	POSTAGE AND SHIPPING										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	TOTAL OCCUPANCY EXPENSE										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

						Direct Service Cost					
Acc No.	Account Title	1 Total Expense	2 Fund-Raising Costs	3 Other Nonreim-burseable Costs	4 Adjusted Cost: Col 1 minus Cols 2 & 3	5	6	7	8	9	10 Indirect Service Cost
3100	OUTSIDE PRINTING AND ART WORK										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	TOTAL TRANSPORTATION										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	TOTAL CONFERENCES AND CONVENTIONS										
3400	SUBSCRIPTIONS AND PUBLICATIONS										
3510	Clothing and Personal Needs										
3520	Other										
3500	TOTAL ASSISTANCE										
4100	ORGANIZATION MEMBERSHIPS										
4200	AWARDS AND GRANTS										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	TOTAL EQUIPMENT REPAIRS & PURCHASE										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	TOTAL DEPRECIATION										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	TOTAL MISCELLANEOUS										
TOTAL EXPENSES											
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
Acc No.	Account Title	1 Total Expense	2 Fund-Raising Costs	3 Other Nonreim-burseable Costs	4 Adjusted Cost: Col 1 minus Cols 2 & 3	5	6	7	8	9	10 Indirect Service Cost
3100	OUTSIDE PRINTING AND ART WORK										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	TOTAL TRANSPORTATION										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	TOTAL CONFERENCES AND CONVENTIONS										
3400	SUBSCRIPTIONS AND PUBLICATIONS										
3510	Clothing and Personal Needs										
3520	Other										
3500	TOTAL ASSISTANCE										
4100	ORGANIZATION MEMBERSHIPS										
4200	AWARDS AND GRANTS										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	TOTAL EQUIPMENT REPAIRS & PURCHASE										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	TOTAL DEPRECIATION										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	TOTAL MISCELLANEOUS										
TOTAL EXPENSES											
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency _____		
Period of Report	From _____	To _____

SCHEDULE E: COMPARATIVE BALANCE SHEET**ASSETS, LIABILITIES, AND EQUITY**

	BALANCE AT END OF	
	Current Period	Prior Period
ASSETS:		
Cash _____	\$ _____	\$ _____
Receivable from clients _____	_____	_____
Receivable from others _____	_____	_____
Property and equipment:		
Land _____	_____	_____
Buildings and equipment _____	_____	_____
Less allowance for depreciation _____	_____	_____
Net property and equipment _____	_____	_____
Investments and other assets _____	_____	_____
TOTAL ASSETS.....	_____	_____
LIABILITIES AND EQUITY:		
Accounts payable _____	\$ _____	\$ _____
Accrued taxes (payroll and property) _____	_____	_____
Other liabilities _____	_____	_____
_____	_____	_____
Notes and mortgages _____	_____	_____
Total liabilities _____	_____	_____
Equity or fund balance _____	_____	_____
TOTAL LIABILITIES AND EQUITY.....	_____	_____

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	\$ _____
Add:	
TOTAL REVENUE from Schedule A _____	\$ _____
Other revenue. Explain _____	_____
_____	_____
_____	_____
Deduct:	
TOTAL EXPENSES from Schedule D _____	_____
Other expenses. Explain _____	_____
_____	_____
_____	_____
TOTAL EQUITY OR FUND BALANCE END OF PERIOD	\$ _____

Provider Agency		Vendor No.
Period of Report:	From	To

SCHEDULE F: COST ALLOCATION PROCEDURES
(To be completed by providers which offer more than one service)

Costs are allocatable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocatable to a service if it is treated consistently with other costs incurred for the same purpose in like circumstances, and if it:

- (1) Is incurred specifically for the service,
- (2) Benefits the service and can be distributed in reasonable proportion to the benefits received, and
- (3) Is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocatable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies or to avoid other restrictions imposed by law or terms of an award.

DIRECT COSTS:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your method of allocating joint service cost consistently followed from year to year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are costs allocated to services in reasonable proportion to benefits received? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Additional comments regarding allocation of joint service costs: | <input type="checkbox"/> | <input type="checkbox"/> |

INDIRECT COST:

- | | | |
|---|--------------------------|--------------------------|
| 1. Are indirect costs distributed on a basis of total direct service or cost? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used? | | |
| 3. Is the basis for distributing indirect cost the same as that used in the previous year? | <input type="checkbox"/> | <input type="checkbox"/> |

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 1

A	B	C	D	E	F	G	
		Shelter Care					
Account Number	Account Title	Attribution Cost	Allowable Allocation of Cost	Total Costs	Allocation of Total Cost to: Maintenance	Service	Basis of Allocation
from 2190	Food Service & Maintenance Workers Salaries					*****	Definition
% of 2200	Food Service & Maintenance Workers Benefits					*****	Definition
% of 2300	Food Service & Maintenance Workers Payroll Taxes					*****	Definition
2130	Direct Care Staff Salaries						Time
% of 2200	Direct Care Staff Benefits						Time
% of 2300	Direct Care Staff Payroll Taxes						Time
from 2120	Other Direct Staff (C1 in/pgm. Supv/SW-Thpst/Nurse)						Time
% of 2200	Other Direct Staff Benefits						Time
% of 2300	Other Direct Staff Payroll Taxes						Time
from 2110	Other Admin. Staff (Clinical/Pgm Supv or Mgr) Salaries						Time
% of 2200	Clinical Supervisor Benefits						Time
% of 2300	Clinical Supervisor Payroll Taxes						Time
2450	Medical & Psychological Services Purchased				*****		Definition
2490	Other Non-Medical Services Purchased				*****		Definition
2530	Medical Supplies					*****	Definition
2540	Recreation ("Family-Like") & Craft Supplies					*****	Definition
	Formalized Non "Family-Like" Recreation				*****		Definition
2550	Food					*****	Definition
3510+352	Clothing, Personal Needs, School Supplies, and Other					*****	Definition
2810	Rent of Space						Sq Ft. -
2820	Building and Grounds Supplies						Sq Ft. -
2830	Utilities						Sq Ft. -
2840	Care of Building and Grounds						Sq Ft. -
2870	Interest on Building and Grounds						Sq Ft. -
2880	Insurance and Property Taxes						Sq Ft. -
2890	Other Occupancy Expenses						Sq Ft. -
Schedule G	Part 1	TOTALS					Sq Ft. -Use
Service/Maintenance Percentages							

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 2

Residual Cost NOT Included in Schedule G, Part 1	Gross Total Attributable to:
	Shelter
Remainder of Program <u>Direct</u> Costs (Total Program Schedule D Direct - Part 1 Direct)	
Remainder of Program <u>Indirect</u> Cost (Total Program Schedule D Direct - Part 1 Indirect)	
PROGRAM TOTALS for PART 2	

UNIT COST DETERMINATION

SERVICE PERCENTAGE FROM SCHEDULE G PART 1

TOTAL PART 2 SERVICE COST

TOTAL SERVICE COST FROM PART 1

GRAND TOTAL SERVICE COST

DEDUCTIONS FROM SERVICE COST FROM SCHEDULE D

GRAND TOTAL SERVICE COST AFTER DEDUCTIONS

MAINTENANCE PERCENTAGE FROM SCHEDULE G PART 1

TOTAL PART 2 MAINTENANCE COST

TOTAL MAINTENANCE COST FROM PART 1

GRAND TOTAL MAINTENANCE COST

DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D

GRAND TOTAL MAINTENANCE COST AFTER DEDUCTIONS

UNITS OF SERVICE**SERVICE COST PER UNIT****MAINTENANCE COST PER UNIT**

TOTAL COST PER UNIT

ALLOCATION OF STAFF TIME WORK SHEET

(Use separate form for each staff type)

TYPE OF STAFF: _____

Enter the percent of time spent on maintenance activities here: _____ LINE 1

Enter the percent of the time spent on service activities here: _____ LINE 2

Add line 1 and line 2 and enter result here: _____ LINE 3

Divide line 1 by line 3 and enter result here: _____ LINE 4

Divide line 2 by line 3 and enter result here: _____ LINE 5

Enter the percent of time spent on administrative activities here: _____ LINE 6

Multiply line 4 by line 6 and enter result here: _____ LINE 7

(This is the percentage of administrative
time allocated to maintenance.)

SUBTRACT line 7 from line 6 and enter result here: _____ LINE 8

(This is the percentage of administrative
time allocated to service.)

ADD line 1 and line 7 and enter result here: _____

(This is the total percentage of time
allocated to maintenance. Use this
percentage to allocate staff cost to
maintenance.)

ADD line 2 and line 8 and enter result here: _____

(This is the total percentage of time
allocated to service. Use this percentage
to allocate staff cost to service.)

* The combined percent of time spent on maintenance, service, and administrative activities should total 100%.

Page 82 is intentionally blank.

Iowa Department of Human Services
SUPPLEMENTAL SCHEDULE

HCBS SUPPLEMENTAL SCHEDULE-D-1 TO FORM 470-0664

CALCULATION OF CONSUMER ITEM LIMITS

(Complete one schedule for each living site or program)

Program					
Column(s) From Schedule D					
From Schedule D: Line 3290 - Other Related Transportation					
Line 3520 - Other					
Line 4320 - Other Equipment Repair and Purchase					
Total					
Divided by the Number of Unduplicated Consumers (from provider records)					
Average Amount per Consumer					
Limit	1570	1570	1570	1570	1570
Variance					

This calculates an average per consumer. The facility is still responsible for justifying actual costs per consumer that exceed the limit.

HCBS SUPPLEMENTAL SCHEDULE-D-2 TO FORM 470-0664

CALCULATION OF INDIRECT COST LIMITS

(Complete one schedule for each living site/program)

Program				
Column(s) from Schedule D				
Total Service or Maint. Cost After Allocation of Indirect				
Less: Direct Costs (HCBS program columns only):				
Line 2120 - Professional Direct Staff				
Line 2130 - Other Direct Staff				
Line 2200 - Total Benefits for Direct Staff				
Line 2300 - Payroll Taxes for Direct Staff				
Line 3210 - Mileage and Auto Rental				
Line 3250 - Agency Vehicle Expense				
Line 3290 - Other Related Transportation				
Line 3520 - Other				
Line 4320 - Other Equipment Repair and Purchase				
Subtotal of Direct Cost				
Calculated Indirect Cost (Total Costs Net of Direct Costs)				
Limitation (20% of the Subtotal of Direct Cost)				
Difference (to Schedule D-3 if exceeds limit)				

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Program				
Column(s) From Schedule D				
Unadjusted Total Cost After Deductions-Schedule D				
Less: Adjustment for Indirect Cost - Schedule D-2				
Adjusted Costs				
Divided by Total Units (certification page section C, line 4)				
Total Unit Cost				
Lower of Unit Cost or Maximum Reimbursement Rate				
Multiplied by DHS Units (certification page section C, line 5)				
Total DHS Cost				
Comparison of Costs and Payments:				
Revenues Billed (from provider records)*				
Less DHS Cost (above)				
Subtotal				
Less DHS Cost X 2.5%				
Balance Due Medicaid Program (If negative, no balance is due.)				

*For reconciliation of revenues billed, see page 2.

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Programs				
Column(s) From Schedule D				
Total Payments Received for Current Period				
Payments Not Yet Received for Current Period				
Total Revenues Billed				

Note: The section below need not be completed for the reporting period ended 6/30/97. This information will need to be collected for future reporting periods.

FOR USE IN CALCULATION OF IN- AND OUT-OF-COUNTY RATES FOR SCL HOURLY SERVICES:

Travel Allocation

Time Spent

In	Out	Total

HCBS SUPPLEMENTAL SCHEDULE-D-4 TO FORM 470-0664

DAILY RATE WORKSHEET

Site Name: _____

No. of Consumers Served: _____

Form 1703-0 Line:

2120 - Professional Direct Staff (Direct Hours _____)

2130 - Other Direct Staff (Direct Hours _____)

2200 - Direct Staff Benefits

2300 - Direct Staff Payroll Taxes

3210 - Mileage and Auto Rental (Numbers of Miles _____)

3250 - Agency Vehicle Expense (Number of Miles _____)

3290 - Other Related Transportation*

3520 - Other (Consultation Expenses)*

4320 - Other Equipment Repair and Purchase*

Total Direct Expense

Indirect Expense (limited to 20% of direct expense)

Total Cost

Number of Units Provided

Unit Cost

*The sum of these lines is limited to \$1570 annually per customer

For Projected Rates:

Effective date _____

☐ All Consumers-Site Rate
OR

☐ Consumer _____ of _____

Request to Exceed the Unique Rate Maximum:

Explanation of reasons for exceeding maximum (i.e. ratio of mid management staff to consumers on caseload or percentage of time charged. Hourly wage of direct staff, description of staffing pattern, description of other support services and resources sought and not available, description of expenses listed in lines 3290, 3520, and 4320 and identification of other resources sought and not available.)

For Projected Rates:

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Facility)	Date
---	------

HCBS SUPPORTED COMMUNITY LIVING INITIAL HOURLY RATE CALCULATION SUPPORTIVE WORKSHEET

Part A: Billable Hours (for an annual period)

ITEM	Instructions	Column 1	Column 2
TOTAL AVAILABLE HOURS: ___ FTEs X 2,080 hours/year	From FSR: Schedule B (professional and direct only); -should equal D-4, 2120 + 2130		
VACATION & HOLIDAYS (subtract): ___ FTEs X ___ days X 8 hours/days =	FTEs (same as above); number of days for vacation and holidays per year		
SICK LEAVE (subtract): ___ FTEs X ___ days X 8 hours/days =	FTEs (same as above); average sick leave usage per year per person		
ADMINISTRATION (subtract): ___ % X ___ hours (see total available hours shown above)=	% of time professional and direct staff spend doing administrative work		
TRAVEL (to consumer locations): (subtract): In county ___ % X ___ hours (see total available hours shown above)= Out of county ___ % X ___ hours (see total available hours shown above)=	% of time professional and direct staff spend traveling from site to site in county and, if applicable, out of county		
UNBILLABLE HOURS (subtract): ___ % X ___ hours (see total available hours shown above)=	% of down time: time when planned activity cannot or did not occur (maximum of 5%)		
TOTAL ANNUAL BILLABLE HOURS			


Part B: Hourly Rate

DIRECT COST (annual amount)	From 470-0664, Schedule D		
INDIRECT COST	From 470-0664, Schedule D (maximum is 20% of direct)		
TOTAL HOURLY COST	Sum of direct and indirect		
DIVIDED BY TOTAL BILLABLE HOURS FROM ABOVE			
HOURLY RATE			

Use Column 1 for calculating the hourly rate for supported community living services provided in the county in which you are located.

Use Column 2 for calculating the hourly rate for supported community living services provided in any other county. (The assumption is that there will be one hourly rate for out-of-county supported community living services, whether it is for one county or twenty counties.)

Signature	Signature
HCBS Agency	CPC County

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D. Instructions for Completing Financial and Statistical Reports

Enter identifying information at the top of each schedule. All information called for in the schedules must be furnished unless it does not apply to your agency.

The cost reporting period is from July 1 through June 30. If you are participating in the program as of July 1, the report covers the 12-month period of July 1 through June 30. When you are entering the program after July 1, your first reporting period is from the beginning of providing MR waiver services through June 30.


If you are a new provider and don't have historical costs, you may complete the report using projected costs. Only the certification page and Schedule D of form 470-0664 and the *Supplemental Schedule* (form 470-3449) are required.

Make adjustments to convert to an accrual basis of accounting if your records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing care and services to consumers on a basis that is fair and comparable among providers of the service.

If you also provide services not contracted for under the HCBS MR waiver contracts, complete the cost apportionment in accordance with recognized methods and procedures for a fair presentation of expense attributable to services provided under the contract.

Do not report costs reported under the waiver as reimbursable costs under any other funding source. Do not report costs incurred for other services as reimbursable costs under the waiver.

If you maintain an out-of-county supported community living service paid at hourly rates, you must report of in-county and out-of-county rates. You may set up in-and out-of county rates through an initial projection and then maintain them by special reporting on the annual *Financial and Statistical Report*.

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“In-county” is defined as the county where the main office is located. “Out-of-county” is all other counties where services are provided.

Accumulate travel time by “in” and “out” counties. Allocate SCL hourly costs between the in-county and out-of-county designations based on travel time. Also accumulate on hourly units provided for SCL an “in-county” versus an “out-of-county” basis in order to continue to set two separate rates.

1. Certification Page

The purpose of the certification page is to report agency statistical information and record the signature of authorized officer of the agency.

Agency name and address: Enter the official name and address of your agency. Generally this is the name and address which appears on the license or official agency letterhead.

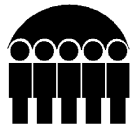
IRS ID No.: Enter the number assigned the facility for tax purposes (federal withholding, etc.).

Contract No.: Enter the contract number assigned to you at certification.

Period of report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and Telephone Numbers: Self explanatory.



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Audit: Indicate if the agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Control: Indicate the ownership under which the agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- ◆ Accrual: Recording revenue when earned and expenses when incurred.
- ◆ Modified Cash: Combination of certain cash and accrual method of accounting.
- ◆ Cash: Recording revenue when received and expenses when paid.


If you do not use the accrual basis of accounting, you must adjust record amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter service codes as entered on Schedule D. Each program and living site should be shown separately.

Enter the appropriate number of units for the reporting period. Billable time means direct support contact with the consumer. For daily units, the number of units of services staffed should be based upon a 365-day period (366 days during a leap year).

Total hours at the end of the month. Round partial units up to the next unit. Divide billable hours equally among consumers when the consumer to staff ratio is greater than 1:1.

Signatures: The report must be reviewed and signed by an authorized officer or administrator of the agency. If the report is prepared by someone other than an employee of the agency, that person must sign.

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2. **Schedule A**

The purpose of Schedule A, “Revenue Report,” is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from excluded or non-home- and community-based MR waiver programs.

Report the total revenues or gross income in the column headed “Total Revenue.” Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report: fees for service, other income, and contributions. These revenue sources are further explained as follows:

- ◆ Fees for services represent income earned by the provider as a result of performing services to or for consumers. The fees might be paid by third parties on behalf of consumers for which services were performed.
- ◆ Service, reimbursement or investment income includes program revenues from the sale of products, food reimbursements for the Department of Education, and investment income which:
 - Is not from restricted or appropriated contributions and
 - Is held separate and not commingled with other funds.

Other income sources may be applicable. If so, identify them accordingly or support them by an accompanying schedule.

- ◆ Contributions must be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included in the Department’s reimbursement rate determination, unless the moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the Department.



The column titled “Revenue for Schedule D Expense Deduction” is used to report those revenues which are required to be deducted from service costs. The revenue shown in this column are deducted from service costs at the bottom of page 2 of Schedule D.

Report revenue which is required to be deducted under both the “Total Revenue” column and also in the “Revenue for Expense Deduction” column.

Income which must be offset against service costs includes all service income generated for that service, such as:


- ◆ Work service revenues.
- ◆ Reimbursements for certain expenses (excluding fees for services).
- ◆ Certain income from investments.

Government grants not restricted or appropriated must be included in the “Revenue for Schedule D Expense Deduction” column to the extent of the related grant expenses included on Schedule D.

If a government grant is for a service and there are associated expenses included in the service which the grant covers, the grant money must be subtracted off of Schedule D. (This means the grant is included in determining the rate.)

If a government grant is applied to costs not shown as costs in a service, the grant income is not used in rate determination.

Contributions that are restricted for capital expenditures, designated to fund service operating deficits or nonreimbursable costs, or provided to fund a required operating reserve are not required to be deducted from service expenses on Schedule D.

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3. Schedule B

The purpose of Schedule B, “Staff Numbers and Wages,” is to report full-time equivalent numbers of staff and wages by job title.

Job Classification and Title: Enter the job titles in the space provided on the left. All personnel must be separated into the following job classifications:

- ◆ 2110 Administrative
- ◆ 2120 Professional
- ◆ 2130 Direct Client Care
- ◆ 2150 Clerical
- ◆ 2190 Other Staff Wages

Number of Staff: Enter the number of persons working full time or part time, and the total full-time equivalents (FTEs) for each job title. (For example, a person working half time has an FTE of 0.5.)

Gross Wages: Enter the gross wages for all full-time and part-time staff for each job title.

After the columns are completed, enter subtotals and total as indicated.

4. Schedule C

The purpose of Schedule C, “Property and Equipment Depreciation and Related Party Property Cost,” is to report information related to depreciable assets. Schedule C includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider.

If property is being leased from a related party, information regarding the lessor’s costs must be submitted on Schedule C.

The totals reported on Schedule C are reported on Schedule D, account 4400. Ongoing expenses, such as maintenance and repairs for this property, are entered on Schedule D under subheadings for either 2800 (occupancy) or 4300 (repair expenses).



Note: Any property expenses related to providing room and board are not reimbursable under rule HCBS MR waiver program and should be excluded.

Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow The Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association, for depreciation.

If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least \$5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset, using one of the approved methods of depreciation.

If a depreciable asset has a historical cost of less than \$5,000, or if the asset has a useful life of less than two years, its cost is allowable in the year it is acquired.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand-alone functional capability may be considered on an item-by-item basis.

For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand-alone office furniture (e.g., chairs, free-standing desks) may be considered on an item-by-item basis.

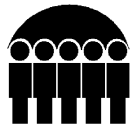
Instructions are provided for each column in the section on provider-owned equipment and buildings:

Original Cost: Record the property and equipment at its original cost.

Depreciation Recorded Prior Years: Obtain this information by adding the depreciation accumulated from prior years less any disposals.

Method: Enter the method used by the agency in calculating its depreciation.

Annual % Rate: Enter the annual percentage rate used in calculating the depreciation.



Recorded Depreciation Expense: Enter the total amount of depreciation recorded on the agency's books.

Straight-Line Depreciation: Enter the amount of depreciation recorded on the property on a straight-line basis if the agency uses a method other than straight-line for its books.

Related Party Property Costs: A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means. Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

If property is leased from a related party, the rent expense must be classified as a nonreimbursable cost on Schedule D, with the actual cost of the property substituted. A schedule of lessor's cost is included on Schedule C for purposes of identifying the actual cost incurred by the related party landlord.

5. Schedule D


The purpose of Schedule D, "Expense Report," is to report total agency expenses and allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for your agency and should be consistent with the costs included on your general ledger.

The account numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

HCBS uses several supplemental schedules to further clarify the application of these expenses.

a. Column Descriptions

Total Expense (Column 1): This column shows the total operating costs of the agency.

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Fund-Raising Costs (Column 2): Use this column to show any adjustment to remove costs related to fund raising activities from allowable costs.

Other Nonreimbursable Costs (Column 3): Use this column to show any adjustments or reclassifications related to costs that are not reimbursed by the HCBS program. Examples of nonreimbursable costs include:

- ◆ Difference between book depreciation expense and that under the straight line method.
- ◆ Expenses not related to providing consumer care (personal expenses).



- ◆ Costs of consumer items provided that exceed the \$1570 limit per consumer. (See **Schedule D-1** for the consumer item limit calculation.)

You can use the nonreimbursable column to reclassify costs, such as:

- ◆ Moving agency vehicle depreciation to a direct cost line when the vehicle is used solely for the HCBS program.
- ◆ Moving food costs that are provided to the consumer at the provider site under the respite program.

Adjusted Costs (Column 4): This column shows costs that are allowable and allocable to HCBS programs, other programs, and indirect administrative costs. Indicate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (fund-raising and nonreimbursable costs).

Direct Service Cost (Column 5 through 9 and 11 through 20, as needed): Use these columns for direct costs for each of the services or service sites provided, as defined below. Report direct costs by hourly service and by site.

In this accounting procedure, “direct” service expense includes all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor’s time.

Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific **consumer** (hands-on, one-on-one consumer contact).

Examples of nonbillable direct costs:

- ◆ Mileage costs for travel to and from the consumer site
- ◆ Time spent in staff meetings related to a particular consumer/HCBS service
- ◆ Time spent documenting services provided



Include in direct costs only the following specified line items related to the direct wages allocated:

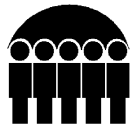
- ◆ Line 2120: Professional Direct Care Staff
- ◆ Line 2130: Other Direct Staff
- ◆ Lines 2210-2290: Direct Staff Benefits
- ◆ Lines 2310-2350: Direct Staff Payroll Taxes
- ◆ Line 3210: Mileage and Auto Rental
- ◆ Line 3250: Agency Vehicle Expense
- ◆ Line 3290: Other Related Transportation
- ◆ Line 3520: Other
- ◆ Line 4320: Other Equipment Repair and Purchase

Show indirect costs in Column 10 **only**. Do not include indirect administrative costs in Columns 5-9.

Indirect Service Costs (Column 10): This column should include those service and administrative expenses which cannot be directly related to any specific service. Indirect costs after adjustments for fund-raising and nonreimbursable costs should be shown in column 10. Some examples of indirect administrative cost are:

- ◆ Staff development and training
- ◆ Receptionist position
- ◆ Office supplies
- ◆ Telephone
- ◆ Rent for administrative office
- ◆ Property or liability insurance

Show all indirect costs by line item in column 10 and then allocate them in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.



All line items may be used as appropriate to report indirect costs in column 10. All lines not specifically addressed under direct costs (above) should be used only for costs indirectly associated with the MR waiver program. There may be some cases where it is necessary to show indirect column 10 costs for those lines previously discussed as direct cost lines.

Indirect costs are limited to 20% of direct costs. See **Supplemental Schedule D-2** for calculation of the limit and any necessary adjustment.

b. Accounting Title Descriptions

This section includes additional instructions for reporting selected line items.

Line 2120: Professional Direct Staff. These positions provide assistance and support to direct support staff, may provide some direct service to the consumer in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost.

Line 2130: Other Direct Staff. These positions provides direct support and assistance to the consumers. The wage amount is cash compensation and may also include noncash compensation of room and board, when applicable.

Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress note, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.



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This item also includes contract services that provide direct support and assistance to consumers. The position is instead of, or in addition to, a direct support employee. Contract payments are made to persons who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the Individualized Case Plans.

Line 2290: Other Benefits. This item includes other benefits provided for employees, excluding travel and training costs.

Line 3210: Mileage and Auto Rental. This item includes staff mileage and expense. Mileage to and from the service site may be included as an indirect expense. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3250: Agency Vehicles Expense. Include expense for operation and maintenance of agency-owned vehicles used for the MR waiver program. Employee mileage to and from the service site in an agency vehicle may be included as a direct cost. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3290: Other Related Transportation. Include expense attributable to the actual transporting of the consumer (provided by staff, taxi, car pool, and bus fare) to allow the consumer to have access to community resources and opportunities.

For supported community living, this item cannot pay for any mode of transportation that provides transportation to work. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1.**)

Line 3520: Other. Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of instructional activities identified in the consumer's ICP. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1.**)



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Line 4320: Other Equipment Repair and Purchase. Include expense amounts for the modification or repair of the consumer's living unit. Expenses included may provide for reasonable accommodation of the behaviors of the consumer in rental units.

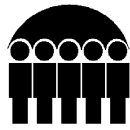
For consumer-owned units, minor maintenance expenses may be included. Also, include household furnishings needed by the consumer. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1.**)

Line 3310: Staff Development and Training. Include all registration, tuition costs, travel, and living expenses incurred by the agency in sending staff members or volunteers to regional and national conferences or to workshops or institutes.

Also show the travel and other costs incurred by an agency in bringing in an outside consultant to conduct a training institute in the agency for conferences or institutes in this item. All training should be classified as an indirect expense in column 10.

All contributions must be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included in the Department's reimbursement rate determination, unless the moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the Department. (Refer to instructions for Schedule A of form 470-0664 for information concerning government grants.)

- ◆ Total Expenses. Enter sum for each respective column.
- ◆ Allocation of Indirect Service Costs. Enter the amount of indirect service costs allocated per each direct service according to the allocation method selected.



- ◆ Total Service or Maintenance Costs After Allocation of Indirect. Enter sum of “Total Expenses” and “Allocation of Indirect Service Costs” for each respective column.
- ◆ Service, Reimbursement or Investment Income. Enter service, reimbursement or investment income from Schedule A per respective service.
- ◆ United Way Contributions Restricted for Specific Individuals. Enter United Way contributions restricted for specific individuals from Schedule A for each service.
- ◆ Other Contributions Restricted for Specific Individuals. Enter other contributions restricted for specific individuals from Schedule A for each service.
- ◆ Government Grants. Enter government grants from Schedule A for each service.
- ◆ Total Service or Maintenance Costs After Deductions. Subtract the amounts described in items 4-7 above and identified with an asterisk on Schedule D from the amount described in item 3 above (Total Service of Maintenance Costs After Allocation of Indirect).

6. Supplemental Schedule D-1

The purpose of HCBS Supplemental Schedule D-1, “Calculation of Consumer Cost Limits,” is to calculate an average cost per consumer for consumer needs items and to determine the reasonableness of these items.

A consumer is eligible for \$1570 of consumer items on an annual basis. The 12-month total of Schedule D lines 3290, Other Related Transportation; 3520, Other; and 4320, Other Equipment Repair and Purchase, cannot exceed \$1570 per consumer. These costs need to be accumulated on an annual basis, with adjustments made for any excesses over the limit.



These expenses are defined as specific costs associated to the consumer. First seek all payment of these expenses from the consumer; second, from community resources; and third, from the HCBS program. The agency is responsible for tracking consumer costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per consumer adequately.


Complete a column for each living site or service. Carry over the consumer item costs from Schedule D. Divide the total costs by the number of unduplicated consumers at each living site for the current period. Compare the amount per consumer against the limitation of \$1,570 for each service per living site. Multiply any excess by the number of unduplicated consumers to obtain the total variance.

7. Supplemental Schedule D-2

The purpose of HCBS Supplemental Schedule D-2, "Calculation of Indirect Cost Limits," is to calculate the indirect administrative cost limit of 20% of direct costs and to compare actual indirect costs allocated to HCBS services to that limit. This schedule compares actual indirect costs allocated to a living site or service against the limitation of indirect expense to 20% of direct costs.

Complete a column for each living site or service. Carry over the total expense by facility and service from the Total Expense line on Schedule D. This is the total expense, including the direct expense and the allocation of the indirect expense but before any income deductions. Carry over direct costs from the corresponding lines on Schedule D for each HCBS program and service. Calculate indirect costs by subtracting these direct expenses from the total.

Calculate the limit of 20% of direct costs using the subtotal of the direct costs lines. Compare this limitation against the calculated indirect expense. Carry forward any excess over the 20% limit to Supplemental Schedule D-3.

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8. Supplemental Schedule D-3

The purpose of HCBS Supplemental Schedule D-3, “Reconciliation of Costs and Payments,” is to document cost per visit by service and to compare costs incurred to payments received. All prospective rates are subject to retrospective adjustment based on reconciliation of provider’s reasonable and proper actual service costs with the revenues received for those services.


File only one schedule for the HCBS program, showing all HCBS services. Carry to this schedule the direct costs plus indirect costs less any deduction on Schedule D. Costs may be combined into columns by service code. Also include any adjustment calculated on Schedule D-2. Then calculate total net costs of the other schedule adjustments per service code.

The next section of the schedule compares Medicaid’s portion of the costs on the report to revenues billed from the Medicaid program. Use the lower of the adjusted costs per unit computed in the first part of schedule or the capped rate for the service multiplied by DHS units as the DHS cost to compare against revenues billed.

“Revenues billed” means payments received for a service category provided in the specified period and payments accrued, but expected to be received, for those services provided in the same period. These revenues figures come from provider records. Include only those payments received or expected to be received for the current period.

A balance due the Medicaid program may occur. Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the Division of Medical Services. Remit the balance due when the *Financial and Statistical Report* is filed.

If you do not reimburse revenues exceeding 2.5 percent of actual within 30 days after the Department gives notice, this amount will be deducted from your future payments.

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9. Supplemental Schedule D-4

The purpose of HCBS Supplemental Schedule D-4, “Daily Rate Worksheet,” is to calculate the unit daily rates cost per living site. Costs reported by site should be consistent with those reported on Schedule, less any adjustment for the limit on indirect administrative costs.

If separate rates are needed for different consumers at a site, submit a Schedule D-4 for the site rate along with separate schedules for each consumer. (For the MR waiver, this could include consumers with different counties of legal settlement.) Indicate the number of consumers at the site and the site name.

Show direct costs by line item. Use actual costs for living sites not undergoing any significant change. Use projected costs if there are no representative historical costs available. Project the costs on an annual period. Complete spaces to show direct hours and miles. Show the lower of actual indirect costs or the 20% limit and add it to total direct costs. Then divide total costs by the units of service provided to calculate a unit cost.

For a living site that undergoes a significant change during the reporting period, this schedule may be submitted based on projected costs. A “significant” change occurs when a consumer’s functioning level changes or you are unable to fill a vacancy within 30 days. Give a full explanation of the changes in the living site situation at the bottom of the schedule. Also give reasons for a request to exceed the unique rate maximum.

A living site rate may be adjusted no more than once every 3 months for the above reasons. The projected rate will not be inflated by the consumer price index (CPI).

10. Schedule E

The purpose of Schedule E, “Comparative Balance Sheet,” is to report the balance sheet of the provider as of the end of the reporting period.

Under “Assets, Liabilities, and Equity,” the total assets must equal the total liabilities and equity.



Balance at End of Current Period: Enter the amount in effect for the last day of the reporting period.

Balance at End of Prior Period: Enter the amount in effect for the last day of the previous reporting period.

Under “Reconciliation of Equity or Fund Balance,” the “add” and “deduct” entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.

Total Equity or Fund Balance Beginning of Period: This amount should be the same as the total liabilities and equity for the “balance at end of prior period.” Add revenues from Schedule A and deduct expenses from Schedule D.


Total Equity or Fund Balance End of Period: This amount should be the same as the total liabilities and equity for the “balance at end of current period.”

11. Schedule F

The purpose of Schedule F, “Cost Allocation Procedures,” is to report other supplemental information related to agency operations and accounting procedures. Complete Schedule F when your agency provides more than one service or service component.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider’s indirect costs. “Direct” costs are those which are directly identifiable to services or components. “Indirect” costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See **Schedule D** for examples.)

The schedule provides questions about methods used in allocating expenses which benefit more than one service or service component. You should be able to support the basis used in allocating these costs. You may be required to obtain prior approval of the cost allocation plan from the regional office.

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E. Rates Based Upon the Submitted Report

If you are a new provider who has not submitted an annual report including at least six months of actual, historical costs, you will be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period, as reported in forms 470-0664 and 470-3449.

When you have submitted an annual report including at least six months of actual, historical costs, you will be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation. The base period is the period covered by the first financial and statistical report you submitted to the Department after 1997 that includes at least six months of actual, historical costs.

Reasonable and proper costs in the base period are inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

After establishment of the initial prospective rate for an established provider, the rate is adjusted annually, effective for the third month after the month during which you submit the annual cost report to the Department. The annual adjustment is equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

Prospective rates are subject to retrospective adjustment. (See instructions for **Supplemental Schedule D-3.**)

Hourly rates are based on the lesser of the actual cost per unit of the base period reported on Supplemental Schedule D-3 of 470-3449 or the unit maximum.

- ◆ An inflation factor will be added to the cost per unit of the previous reporting period not to allow the rate to exceed the unit maximum.
- ◆ No actual cost-per-unit rates will be set if the period reported is less than six months.
- ◆ No inflation factor will be added to projected rates.



Daily rates are based on the actual cost per unit of the base period reported on Schedule D-4 of form 470-3449 for each site, not to exceed the maximum unit rate:

- ◆ The Division of Medical Services may grant variations when cost effective and in accordance with the ICP. (For the MR waiver, the statewide average rate must remain at or below \$72.17.)
- ◆ No actual cost-per-unit rates will be set if the period reported is less than six months.
- ◆ An inflation factor is added to the cost per unit of the previous reporting period. No inflation factor is added to projected rates.

No rates are set for home and vehicle modification. This service is based upon one-time expenditures and not on a per unit rate.

Projected rates continue to be effective for providers with less than six months of actual cost data. SCL daily site rates that have been revised since the initial rate projection will continue to be in effect if so noted on the submitted *Supplemental Schedule*, form 470-3449.

VI. CLIENT PARTICIPATION

The following sections explain:

- ◆ Requirements for third-party payments.
- ◆ Limits on waiver payment when there is third-party liability.

A. Third-Party Payments

The income maintenance worker:

- ◆ Makes the financial eligibility determination.
- ◆ Determines the amount of client participation and third party liability, if any.
- ◆ Informs the consumer's service worker or Medicaid case manager.

Generally, a consumer eligible for MR waiver services will not have client participation, whether under an FMAP-related, SSI-related, or 300% coverage group.



However a consumer may be eligible to receive third-party vendor payments to cover the costs of some or all waiver services. This includes payments by Medicare, private health insurance, county government, or Veterans Administration aid and attendance. Generally, third-party vendor payments are paid directly to the provider. However, some third-party vendor payments are paid directly to the consumer.

Third-party medical payments that are intended to meet the costs of waiver services and which are paid directly to the consumer are counted for client participation.

Note: Persons who are eligible for waiver services, including those who currently have a health insurance policy, are encouraged to apply for the Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid recipients.

The HIPP program pays for private health insurance for Medicaid-eligible persons when it is determined to be cost-effective. The program pays for the cost of premiums, coinsurance, and deductibles.

B. Limit on Payment

The service worker or Medicaid case manager will notify you of any client participation and whether there is third-party liability. The consumer is responsible for paying applicable client participation and administering third-party vendor payments.

You must bill any third party or collect from the consumer. Bill Medicaid only for the difference between the client participation or third-party liability amounts and the cost for waiver services.

When a consumer receives more than one waiver service, the client participation and any undesignated third-party payments are attributed to services in the following order:

1. Supported community living
2. Respite
3. Supported employment
4. Other waiver services as needed



Bill waiver services showing third-party payments or client participation, even if no third-party or client participation payments are made. Medicaid pays the balance of the cost of waiver services, up to the established limit, after third-party payment and client participation have been applied to the cost of services.

If the consumer has an unused portion of client participation, the consumer retains the unused portion. Client participation is not carried over to the next month.

VII. PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES

The following chart indicates the maximum possible reimbursement rate for all waiver services. The maximum service rates indicated may not reflect your actual costs. Therefore, if your actual costs do not meet the maximum rate identified, you must charge the general public the lesser rate. The lesser rate will be used to calculate the amount that you will bill to the fiscal agent for waiver services provided.

Each service must be billed in whole units.

You are responsible for communicating current service rates to the service worker or case manager who is responsible for writing the service plan for each consumer. Because the service plan authorizes waiver services, current service rates must be included.

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Code	Service	Basis of Reimbursement	Upper Limits
W1021	Adult day care	Fee schedule (half day)	County contract rate or, in the absence of a contract rate, \$27.50 per half day, \$55.00 per full day, or \$70.00 per extended day
W1002	Adult day care	Fee schedule (full day)	
W1203	Adult day care	Fee schedule (extended day)	
W1265	Consumer-directed attendant care, agency provider, hourly	Fee agreed upon by consumer and provider agency	\$18.49 per hour, not to exceed the daily rate of \$106.82 (1-7 hours)



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W1266	Consumer-directed attendant care, agency provider, daily	Fee agreed upon by consumer and provider agency	\$106.82 per day (8-24 hours)
W1267	Consumer-directed attendant care, individual provider, hourly	Fee agreed upon by consumer and individual provider	\$12.33 per hour, not to exceed the daily rate of \$71.90 (1-7 hours)
W1268	Consumer-directed attendant care, individual provider, daily	Fee agreed upon by consumer and individual provider	\$71.90 per day (8-24 hours)
S9122	Home health aide, per hour	Retrospective cost-related	Maximum Medicare rate converted to an hourly rate
W1302	Home and vehicle modifications, per work completion	Contractual rate	\$5,000 per consumer (lifetime)
W2518	Interim medical monitoring and treatment (home health agency) provided by a home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate, not to exceed the maximum daily per diem for ICF/MR level of care
W2519	Interim medical monitoring and treatment-(home health agency) provided by a nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate, not to exceed the maximum daily per diem for ICF/MR level of care
W2520	Interim medical monitoring and treatment-provided by a registered child development home or licensed child care center	Contractual rate	\$12.24 per hour, not to exceed the maximum daily per diem for ICF/MR level of care



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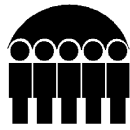
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Service

Basis of Reimbursement

Upper Limits

W1518	Interim medical monitoring and treatment (supported community living provider)	Retrospectively limited prospective rate. See V. E, Rates Based on Submitted Report	\$32.64 per hour, not to exceed the maximum ICF/MR rate per day
S9123 (RN) S9124 (LPN)	Nursing, per hour	Fee schedule as determined by Medicare	Maximum Medicare rate (converted to an hourly rate)
W1304	Personal emergency response system, monthly	Fee schedule	Ongoing monthly fee of \$26.19
W1303	Personal emergency response system, per installation	Fee schedule	Initial one-time fee of \$38.42
W1425	Prevocational services	Fee schedule	County contract rate or, in the absence of a contract rate, \$45.00 per day
W2506	Respite (facility care), hospital or nursing facility providing skilled care	\$12.24 per hour	\$12.24 per hour, not to exceed daily per diem for the skilled nursing level of care
W2507	Respite (facility care), nursing facility	\$12.24 per hour	\$12.24 per hour, not to exceed daily per diem for nursing facility care
W2508	Respite (facility care), intermediate care facility for the mentally retarded	\$12.24 per hour	\$12.24 per hour, not to exceed daily per diem for ICF/MR level of care



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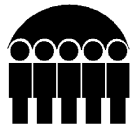
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<u>HCPCS</u> <u>Code</u>	<u>Service</u>	<u>Basis of Reimbursement</u>	<u>Upper Limits</u>
W2509	Respite (facility care), foster group care	\$12.24 per hour	\$12.24 per hour, not to exceed daily per diem rate for rehabilitative treatment and supportive services
W2510	Respite (facility care), camps	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$12.24 per hour, not to exceed \$294 per day
W2511	Respite (facility care), adult day care	\$12.24 per hour	\$12.24 per hour, not to exceed rate for regular adult day care services
W2512	Respite (facility care), child care facilities	\$12.24 per hour	\$12.24 per hour, not to exceed contractual daily per diem
W2516	Respite-(facility care), residential care facility for persons with mental retardation)	\$12.24 per hour	\$12.24 per hour, not to exceed contractual daily per diem
W2503	Respite (home care agency and nonfacility care), specialized respite	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$31.50 per hour, not to exceed \$294 per day
W2504	Respite (home care agency and nonfacility care), basic individual respite	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$16.80 per hour, not to exceed \$294 per day



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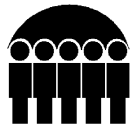
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<u>HCPCS Code</u>	<u>Service</u>	<u>Basis of Reimbursement</u>	<u>Upper Limits</u>
W2505	Respite (home care agency and nonfacility care), group respite	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$12.24 per hour, not to exceed \$294 per day
W2500	Respite (home health agency), specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate, not to exceed \$294 per day
W2501	Respite (home health agency), basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate ,not to exceed \$294 per day
W2502	Respite (home health agency), group respite	Retrospectively limited prospective rates	\$12.24 per hour not to exceed \$294 per day
W1430	Supported employment Activities to obtain a job	Fee schedule	\$500 per job, not to exceed \$1,500 per calendar year
W1300	Supported community living, daily	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$32.64 per hour, not to exceed a total per month of \$73.61 times the number of days in the month. \$73.61 per day when cost-effective and in accordance with the service plan, as long as the statewide average remains at or below \$73.61 per day.



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HCBS MENTAL RETARDATION WAIVER

CHAPTER PAGE

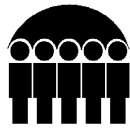
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<u>Code</u>	<u>Service</u>	<u>Basis of Reimbursement</u>	<u>Upper Limits</u>
W1311	Supported community living, hourly	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	\$32.64 per hour, not to exceed a total per month of \$73.61 times the number of days in the month. \$73.61 per day when cost-effective and in accordance with the service plan as long as the statewide average remains at or below \$73.61 per day.
W1320	Supported community living (residential based)	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	The maximum daily per diem for ICF/MR
W1431	Supports to maintain employment: Job coaching	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	Maximum of \$32.64 per hour. Total not to exceed \$2,772 per month and maximum of 40 units per week for W1431, W1432 and W1433.
W1432	Supports to maintain employment: Personal care	Retrospectively limited prospective rates. See V. E, Rates Based on Submitted Report	Maximum of \$18.49 per hour. Total not to exceed \$2,772 per month and maximum of 40 units per week for W1431, W1432 and W1433.



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Code

Service

Basis of Reimbursement

Upper Limits

W1433

Supports to maintain
employment:
Enclave

Retrospectively limited
prospective rates. See
V. E, **Rates Based on
Submitted Report**


Maximum of \$5.78 per
hour. Total not to
exceed \$2,772 per
month and maximum of
40 units per week for
W1431, W1432 and
W1433.

W1414

Transportation

Fee schedule

County contract rate or,
in the absence of a
contract rate, the state
per mile rate (for
individual providers), or
rate set by area agency
on aging.

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I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

When filing claims in a paper format submit billings for waiver services to ACS on the *Claim for Targeted Medical Care*, Iowa Medicaid program, form 470-2486. Copies of this form may be obtained from ACS at (515) 327-5120 or (800) 338-7909. Claims submitted electronically shall be filed on the Accredited Standards (ASC) X12N 837 transaction, Health Care Claim.

Bill ACS for each service rendered to each consumer (recipient) using applicable charges or the rate determined by the Division of Medical Services. The cost limits are presented in Chapter E, Section VII: **PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES**. The maximum Medicaid rates are reviewed annually by the state legislature and, with the Governor's approval, are established effective July 1 for each state fiscal year.

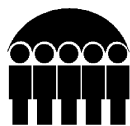
Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for an entire month's service by the tenth of the month following the month of service. **Example:** A recipient received 24 hours of waiver service during the month of June. The claim for June's service should be submitted by the tenth day of July.

The following table contains information to aid in the completion of the *Claim for Targeted Medical Care*, form 470-2486. The table matches field numbers and names on the form, giving a brief description of what information is needed, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

Note: For electronic media claim (EMC) submitters, refer to your EMC specifications for appropriate claim completion instructions.

Training in completing the claim form is available from ACS. Call ACS at the number listed above and request a field representative. A field representative will return the call and schedule a visit with you.



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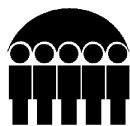
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LOCATOR #/FIELD REQUIREMENTS		LOCATOR NAME	TARGETED MEDICAL CARE CLAIM FORM DESCRIPTION AND INSTRUCTIONS
1	R	STATE ID	Enter the consumer's <u>Medicaid</u> identification number found on the <i>Medical Assistance Eligibility Card</i> . This number consists of seven digits and an ending letter. (For example, 1234567A)
1a	R	CONSUMER ACCOUNT #	Enter the account number assigned to the consumer by the provider of services. This field is limited to 10 alphanumeric characters.
2	R	CONSUMER'S NAME	Enter the last name, first name, and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
3	R	TREATING PROVIDER NUMBER	Enter the seven-digit Medicaid identification number of the treating provider.
4	R	TREATING PROVIDER NAME	Enter the provider name.
5	R	TREATING PROVIDER ADDRESS	Enter the provider address.
6	R	PAY-TO PROVIDER NUMBER*	Enter the seven-digit Medicaid identification number of the billing provider if other than treating provider, e.g., physician = treating; institution = billing.
7		PAY-TO PROVIDER NAME	No entry required.
8	C	OTHER INSURANCE: YES OTHER INSURANCE: NO	If the medical resource codes indicate there is other insurance coverage, or if you are aware of other coverage that will pay, check YES. Enter the amount the other insurance paid in box 12. Leave blank.
9	C	OTHER INSURANCE DENIED: YES	If the other insurance denied, check YES. Be sure to also check YES in box 8.



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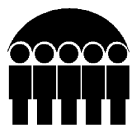
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		OTHER INSURANCE DENIED: NO	Leave blank.
10		SERVICES:	
10A	R	PROCEDURE CODE	Enter the applicable five-digit procedure code.
10B			Leave blank.
10C	O	PROCEDURE DESCRIPTION	Enter a complete description of the service performed.
10D	R	PLACE OF SERVICE	<p>* Enter one of the two-digit codes as follows:</p> <ul style="list-style-type: none">11 Office12 Home21 Inpatient hospital22 Outpatient hospital23 Emergency room - hospital24 Ambulatory surgical center25 Birthing center26 Military treatment facility31 Skilled nursing facility33 Custodial care facility34 Hospice41 Ambulance - land42 Ambulance - air or water51 Inpatient psychiatric facility52 Psychiatric facility partial hospitalization53 Community mental health center54 Intermediate care facility/mentally retarded55 Residential substance abuse treatment facility56 Psychiatric residential treatment center61 Comprehensive inpatient rehabilitation facility62 Comprehensive outpatient rehabilitation facility65 End-stage renal disease treatment71 State of local public health clinic72 Rural health clinic81 Independent laboratory99 Other unlisted facility



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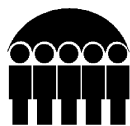
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10E	R	FIRST DATE OF SERVICE *	<p>For the first month of service, enter the first date of service. In subsequent months, enter the first date of the calendar month for which the charge was incurred. The entry must be six digits (MM/DD/YY, for example 03/01/02).</p> <p>If there is client participation from the patient, only one calendar month can be billed per claim form. The county human services worker will inform you if you are to collect client participation from the patient.</p>
10F	R	LAST DATE OF SERVICE *	<p>Enter the last day of the calendar month that was entered in 10E. For the last month of service, enter the last date service was provided. The entry must be six digits (MM/DD/YY, for example 03/31/02).</p> <p>If there is client participation from the patient, only one calendar month can be billed on each claim form. The county human services worker will inform you if you are to collect client participation from the patient.</p>
10G	R	PROVIDER RATES *	<p>Enter the rate that you have been authorized in the care plan to bill Iowa Medicaid. This may be an hourly, daily, monthly, per visit, or per trip, depending on the service provided. Refer to Chapter E for unit rate descriptions.</p>
10H	R	UNITS *	<p>Enter the applicable number of units of service depending upon the procedure code you are billing. Bill only for services that you have provided. Round units for the entire month to the nearest whole number. Refer to Chapter E for procedure code descriptions.</p>
10I		TOTAL CHARGES *	<p>Multiply your provider rate (10G) times the number of units of service (10H). Enter the total charge for the month being billed.</p>



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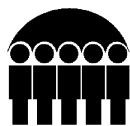
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11	R	TOTAL CHARGE	Enter the total change for all services being billed on this claim form.
12	C	THIRD PARTY LIABILITY *	Enter any insurance payments you have received for this claim. DO NOT enter Iowa Medicaid payments in this box.
13	C	CLIENT PARTICIPATION *	If you have been instructed by the county human services worker to collect a client participation amount from the recipient, enter it here. Otherwise, leave this box blank.
14	R	BALANCE DUE	Subtract the amounts in boxes 12 and 13 from the amount in box 11 and enter the amount due from the Medicaid program.
	R	PROVIDER SIGNATURE	Enter the signature of the authorized representative. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
	R	DATE *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.
	R	CONSUMER/ GUARDIAN SIGNATURE	For consumer-directed attendant care claims, the consumer (or the consumer's guardian, if applicable) must sign here.
	R	DATE *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.



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B. Facsimile of Claim for Targeted Medical Services, Form 470-2486

(See the following pages for a facsimile of the *Claim for Targeted Medical Services*.)

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ Staple the additional information to form 470-3969, *Claim Attachment Control*.
(See the page following the claim form for an example of this form.)
- ◆ Complete the “attachment control number” with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ Do not attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Department of Human Services

CLAIM FOR TARGETED MEDICAL CARE(Please type. Accuracy is important.)**CHECK ONE:**

- ☐ A = ILL & HANDICAPPED WAIVER
 ☐ B = AIDS WAIVER
 ☐ C = ELDERLY WAIVER
 ☐ D = MR WAIVER
 ☐ E = RESERVED
☐ F = BRAIN INJURY WAIVER
 ☐ G = CASE MGT
 ☐ H = RESERVED
 ☐ I = RESERVED
 ☐ J = RESERVED
☐ P = PHYSICAL DISABILITY WAIVER

(A) CONSUMER INFORMATION:

STATE ID:	1	CONSUMER ACCT #:	1a
CONSUMER'S NAME:	2 LAST	FIRST	MI

(B) PROVIDER INFORMATION:

TREATING PROVIDER NUMBER / NAME:	3	/	4
TREATING PROVIDER ADDRESS: (STREET, CITY, STATE, ZIP)	5		
PAY - TO PROVIDER NUMBER / NAME:	6	/	7

8 **OTHER INSURANCE:** ☐ YES ☐ NO9 **OTHER INSURANCE DENIED:** ☐ YES ☐ NO**10 (C) SERVICES:**

A.	B.	C.	D.	E.	F.	G.	H.	I.
PROC CODE		PROCEDURE DESCRIPTION	* PLACE OF SVC	FIRST DATE MM/DD/YY	LAST DATE MM/DD/YY	PROVIDER RATES	UNITS	TOTAL CHARGES
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			

* PLACE OF SERVICE (REFER TO CODES ON BACK)

I certify that the statements on the back apply to this bill and are made a part of it.

PROVIDER SIGNATURE

DATE

For consumer-directed attendant care claims only:

CONSUMER/GUARDIAN SIGNATURE

DATE

TOTAL CHARGE: 11

THIRD PARTY LIABILITY: 12

CLIENT PARTICIPATION: 13

BALANCE DUE: 14

MEDICAID PAYMENTS

(PROVIDER CERTIFICATION)

I hereby agree:

- ◆ To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- ◆ To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- ◆ To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.
- ◆ To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

- ◆ The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- ◆ The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.
- ◆ The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

- | | |
|-------------------------------|---|
| 11 Office | 51 Inpatient psychiatric facility |
| 12 Home | 53 Community mental health center |
| 21 Inpatient hospital | 54 Intermediate care facility/MR |
| 22 Outpatient hospital | 55 Residential substance abuse treatment facility |
| 23 ER room hospital | 56 Residential psychiatric treatment facility |
| 24 Ambulatory surgical center | 61 Comp inpatient rehab facility |
| 31 Skilled nursing facility | 62 Comp outpatient rehab facility |
| 32 Nursing facility | 71 Public health clinic |
| 33 Custodial care facility | 99 Other |
| 34 Hospice | |

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Name _____

Pay-to-Provider Number

--	--	--	--	--	--	--

Recipient Name _____


Recipient State ID Number

--	--	--	--	--	--	--	--

Date of Service / /

Type of Document

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

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II.REMITTANCE STATEMENT AND EXPLANATION

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

A. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.


PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

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If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit minus the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See following pages.)

IAMC8000-R001 (CP-0-12)
AS OF 05/19/97

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

REMITTANCE ADVICE

1. TO: [REDACTED] 2. R.A. NO.: 0000022 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] 4. PAGE: 1

**** PATIENT NAME **** RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /
LAST FIRST MI LINE SVC-DATE PROC/MODS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

*** CLAIM TYPE: WAIVER

*** CLAIM STATUS: PAID

ORIGINAL CLAIMS:

5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
[REDACTED]	[REDACTED]	4-96326-00-131-0055-00	18.	9359.15	0.00	9359.15	0.00	[REDACTED]	000 000
	01	08/01/95 W1300	31	1519.31	0.00	1519.31	0.00	[REDACTED]	B 000 000
	02	09/01/95 W1300	30	1470.30	0.00	1470.30	0.00	[REDACTED]	B 000 000
	03	10/01/95 W1300	31	1862.79	0.00	1862.79	0.00	[REDACTED]	B 000 000
	04	11/01/95 W1300	30	1802.70	0.00	1802.70	0.00	[REDACTED]	B 000 000
	05	12/01/95 W1300	31	1862.79	0.00	1862.79	0.00	[REDACTED]	B 000 000
	06	01/01/96 W1300	14	841.26	0.00	841.26	0.00	[REDACTED]	B 900 000
[REDACTED]	[REDACTED]	4-96340-00-102-0034-00		5197.71	0.00	0.00	0.00	[REDACTED]	000 000
	01	09/09/96 W1300	22	2157.54	0.00	0.00	0.00	[REDACTED]	K 000 000
	02	10/01/96 W1300	31	3040.17	0.00	0.00	0.00	[REDACTED]	K 000 000


REMITTANCE TOTALS

	19.	NUMBER OF CLAIMS			
PAID ORIGINAL CLAIMS:		2	-----	14,556.86	9,359.15
PAID ADJUSTMENT CLAIMS:		0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:		0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:		0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):		0	-----	0.00	0.00
AMOUNT OF CHECK:			-----		9,359.15

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.


Page 12 was intentionally left blank.

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C. Remittance Statement Field Description

1. Pay-to provider name as specified on the *Medicaid Provider Enrollment Application*.
2. *Remittance Advice* number.
3. Date claim paid.
4. Medicaid (Title XIX) pay-to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
12. Medical record number as assigned by provider/Medicaid ID number of provider performing services.
13. Allowed charge source code.

B	Billed charge	F	Fee schedule
K	Denied	N	Provider charge rate
P	Group therapy	Q	EPSDT total screen over 17 years
R	EPSDT total under 18 years	S	EPSDT partial over 17 years
T	EPSDT partial under 18 years	U	Gynecology fee
V	Obstetrics fee	W	Child fee

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14. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.
15. Line item number.
16. The first date of service for the procedure billed.
17. The procedure code for the service billed.
18. The number of units of service rendered.
19. Remittance totals (found at the end of the *Remittance Advice*).
 - ◆ Number of paid original claims/amount billed/amount allowed and paid.
 - ◆ Number of paid adjusted claims/amount billed/amount allowed and paid.
 - ◆ Number of denied original claims/amount billed/amount allowed and paid.
 - ◆ Number of denied adjusted claims/amount billed/amount allowed and paid.
 - ◆ Number of pended claims (in process)/amount billed/amount allowed.
 - ◆ Amount of check.
20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

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III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422


To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *remittance advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

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A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

1. 17-DIGIT TCN																			
-----------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. NATURE OF INQUIRY

I
N
Q
U
I
R
Y

(Please do not write below this line)

FISCAL AGENT RESPONSE

A

1. 17-DIGIT TCN	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
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2. NATURE OF INQUIRY

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470-3744 (Rev. 10/02)

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Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.☐ **CLAIM ADJUSTMENT**

- ◆ Attach a complete copy of claim.
(If electronic, use next step.)
- ◆ Attach a copy of the Remittance Advice with corrections in **red ink**.
- ◆ Complete Sections B and C.

☐ **CLAIM CREDIT**

- ◆ Attach a copy of the Remittance Advice.
- ◆ Complete Sections B and C.

☐ **CANCELLATION OF ENTIRE REMITTANCE ADVICE**

- ◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used.
- ◆ Attach the check and Remittance Advice.
- ◆ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN

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2. Pay-to Provider #:

4. 8-character Iowa Medicaid Recipient ID:
(e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:

Provider/Representative Signature:

Date:

FISCAL AGENT USE ONLY: REMARKS/STATUS

Return All Requests To:

ACS
PO Box 14422
Des Moines, IA 50306-3422

February 24, 1995

For Human Services Use Only

General Letter No. 8-A-AP(II)-546

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 95-1

Subject: HCBS Mental Retardation Waiver Manual, Table of Contents, page 4, revised; and Chapter E, "Coverage and Limitations," pages 1 through 4, 11, 12, 13, 22, 24, 28, 30, and 60, revised.

Some changes are made to update nomenclature. For example, the Bureau of Program Services replaces the Bureau of Institutional and Community-Based Services in the Division of Medical Services. References to the HCBS MR/OBRA waiver program are deleted. Clients eligible for this waiver can be served by the HCBS MR waiver program.

The requirement that the consumer's physician sign the individual comprehensive plan is removed. (Nursing and home health aide providers continue to need a physician's signature on their agency treatment plans due to licensing requirements.)

Service providers who receive Division of Medical Services approval may provide supported community living services to four HCBS MR waiver consumers residing in a living unit when the provider meets certification standards and other criteria. One of the criteria is that the provider uses an existing residential facility structure owned or operated by the provider as of November 9, 1994.

Clarification is included that up to the maximum number of intermittent hours for home health aide and nursing services may be used, when medically necessary.

Clarification is added to the procedure codes to show that the unit of service is an hour for both home health aide and nursing service.

Date Effective

March 1, 1995

Material Superseded

Remove from HCBS Mental Retardation Waiver Manual, Table of Contents, page 4, and Chapter E, pages 1 through 4, 11, 12, 13, 22, 24, 28, 30, and 60, all dated June 1, 1994, and destroy.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

March 7, 1996

For Human Services Use Only

General Letter No. 8-A-AP(II)-585

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 96-1

Subject: ***HCBS Mental Retardation Waiver Manual***, Table of Contents, page 6, revised;
Chapter E, Coverage and Limitations, page 60, revised.

The maximum rate providers may charge for respite is changed to \$12.00 from \$9.27.

Date Effective

February 1, 1996

Material Superseded

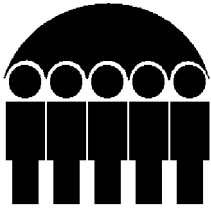
Remove from ***HCBS Mental Retardation Waiver Manual***, Table of Contents, page 6, dated January 1, 1994, and Chapter E, page 60, dated March 1, 1995, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-120

Employees' Manual, Title 8
Medicaid Appendix

June 21, 1999

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Mental Retardation Waiver Manual***, Table of Contents, pages 4, 5, and 6, revised; Chapter E, *Coverage and Limitations*, pages 1 through 61, revised, and pages 62 through 91, new; and Chapter F, *Billing and Payment*, pages 1 through 14, revised.

Chapter E is revised to reflect:

- ◆ The addition of consumer-directed attendant care as a service component under the MR waiver, effective July 1, 1997.
- ◆ Clarification of policies regarding the acceptance of accreditation from another body as a qualification for certification as a waiver provider, effective July 1, 1998.
- ◆ Clarification that interviews with consumers are used only in reviews of supported community living and supported employment services, effective July 1, 1998.
- ◆ The change to outcome-based standards in the accreditation process, effective February 1, 1998.
- ◆ Provisions for conversion of five-bed facilities licensed as residential care facilities for the mentally retarded and eight-bed facilities licensed as intermediated care facilities for the mentally retarded to waiver providers, effective February 1, 1998.
- ◆ Ability of the consumer to remain eligible for the waiver through the receipt of one unit of service per quarter, rather than per month, effective May 1, 1999.
- ◆ Removal of the 16-week limit on supported employment instructional activities on the job, effective May 1, 1999. (The limit of 40 units per week remains in effect.)
- ◆ Changes to the rate-setting process for providers of supported community living, non-facility respite, and supported employment (except instructional activities to obtain a job and follow-along), including a requirement for cost reports and retrospective adjustment based on actual costs, effective July 1, 1998.
- ◆ Rate increases and changes in the upper limit for reimbursement of home health aid service, effective July 1, 1999.

Changes in Chapter F include:

- ◆ A revised claim form that includes the required signature of the consumer or guardian for consumer-directed attendant care, effective May 1, 1999.
- ◆ Updated samples and explanations of the remittance advice issued by the Medicaid fiscal agent, effective July 1, 1997.

Rate-Setting Procedures

Providers of supported community living, non-facility respite, and supported employment enclave settings and instructional activities on the job are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider. (For supported community living, daily rates are calculated for each consumer or site.)

These rates are based on projected or historical costs of operation, subject to maximums and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

Providers are required to submit cost reports for each waiver service provided using form SS-1703-0, *Financial and Statistical Report for Purchase of Service*, and form 470-3449, *Supplemental Schedule*. Failure to submit these forms by September 30 or an extended deadline of up to 30 days granted by the Division of Medical Services shall reduce the payment to the provider to 76 percent of the provider's current rate.

Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source and costs incurred for other services shall not be reported as reimbursable costs under the waiver. Failure to maintain records to support the *Financial and Statistical Report* and *Supplemental Schedule* may result in termination of the provider's HCBS certification.

The prospective rates for new providers are based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period covered by the first *Financial and Statistical Report* and *Supplemental Schedule* submitted to the Department after 1997 that includes at least six months of actual, historical costs.

For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in consumer's needs. Individual prospective daily rates are determined for each consumer.

These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or a consumer's needs have significantly changed. Rates adjusted on this basis become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

An annual adjustment for all providers is made equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

Retrospective adjustments are made based on reconciliation of a provider's actual service costs with the revenues received for those services as reported on the *Financial and Statistical Report* and *Supplemental Schedule*.

Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the Division of Medical services. Payment is due upon notice of the new rates and retrospective adjustment. Providers who do not reimburse excess revenues 30 days after the Department gives notice will have the revenues over 2.5 percent of the actual costs deducted from future payments.

Date Effective

July 1, 1999

Material Superseded

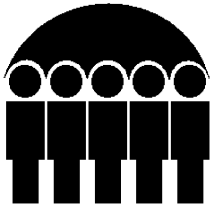
Remove and destroy the following from *HCBS Mental Retardation Waiver Manual*:

<u>Page</u>	<u>Date</u>
Table of Contents (page 4)	March 1, 1995
Table of Contents (page 5)	January 1, 1994
Table of Contents (page 6)	February 1, 1996
Chapter E	
1-4	March 1, 1995
5-10	June 1, 1994
11	March 1, 1995
12	June 1, 1994
13	March 1, 1995
14-21	June 1, 1994
22	March 1, 1995
23	June 1, 1994
24	March 1, 1995
25-27	June 1, 1994
28	March 1, 1995
29	June 1, 1994
30	March 1, 1995
31-59	June 1, 1994
60	February 1, 1996
61	June 1, 1994
Chapter F	
1-14	June 17, 1994

Additional Information

Note that for providers of supported community living, non-facility respite, and supported employment enclave settings and instructional activities on the job, forms SS-1703-0, *Financial and Statistical Report for Purchase of Service*, and 470-3449, *Supplemental Schedule*, for the period July 1, 1998, through June 30, 1999, are due to Ryan, Givens, Wenthe and Company by September 30, 1999.

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services. Direct questions regarding completion of forms SS-1703-0 and 470-3449 to Paula Davis at Ryan, Givens, Wenthe and Company, phone (515)225-3141 or fax (515)224-1233.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-139
Employees' Manual, Title
Medicaid Appendix

March 6, 2000

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Mental Retardation Waiver Manual***, Chapter E, *Coverage and Limitations*, pages 90 and 91, revised.

This manual is revised to:

- ◆ Add a separate procedure code for ongoing personal emergency response services.
- ◆ Reflect an increase in the Medicaid rate for nursing facility care (applied to respite care provided by a nursing facility or ICF/MR).
- ◆ Correct the assignment of procedure codes to supported employment services.

Date Effective

July 1, 1999

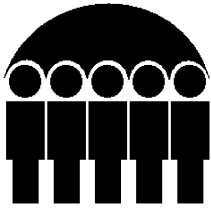
Material Superseded

Remove and destroy the following from ***HCBS Mental Retardation Waiver Manual***:

<u>Page</u>	<u>Date</u>
Chapter E 90, 91	July 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-156
Employees' Manual, Title 8
Medicaid Appendix

September 15, 2000

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 00-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Mental Retardation Waiver Manual***, Table of Contents (page 6), revised; Chapter E, *Coverage and Limitations*, page 90, revised; and Chapter F, *Billing and Payment*, page 4, revised; and pages 15 through 19, new.

The changes to Chapter E reflect out-of-home respite rate changes paralleling facility respite rate changes.

Any changes in rates must be ordered and approved in the consumers' service plans before billing.

The changes to Chapter F revise claim completion instructions for client participation to match narrative instructions and add two forms to be used to resolve problems with submitted claims.

Date Effective

February 1, 2000 for Chapter E revisions

April 1, 2000 for Chapter F revisions

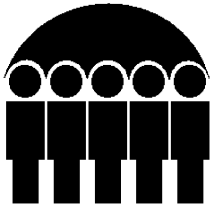
Material Superseded

Remove the following pages from the ***HCBS Mental Retardation Waiver Manual*** and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 6)	July 1, 1998
Chapter E	
90	July 2, 1999
Chapter F	
4	July 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-166

Employees' Manual, Title 8
Medicaid Appendix

May 18, 2001

HCBS MENTAL RETARDATION WAIVER SERVICES MANUAL TRANSMITTAL NO. 01-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS MENTAL RETARDATION WAIVER SERVICES MANUAL***, Table of Contents (pages 4 - 6), revised; Chapter E, *Coverage and Limitations*, pages 1 through 91, revised; pages 92 through 114, new; and Chapter F, *Billing and Payment*, pages 1 and 4, revised.

Summary

This letter transmits changes to the HCBS Mental Retardation waiver that were effective July 1, 2000, and May 1, 2001.

The following changes are effective July 1, 2000:

- ◆ A new service, interim medical monitoring and treatment service, is added.
 - Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers. The services allow the consumer's usual caregivers to be employed. Interim medical monitoring and treatment services may also be provided for a limited period of time for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.
 - Interim medical monitoring and treatment services provide experiences for each consumer's social, emotional, intellectual, and physical development, include comprehensive developmental care and any special services for a consumer with special needs, and include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Services may include transportation to and from school.
 - A maximum of 12 one-hour units of service is available per day. Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. They may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school. The staff-to-consumer ratio shall not be less than one to six.
 - The following providers may provide interim medical monitoring and treatment services: supported community living providers, licensed child care centers, registered group and family child care homes, and home health agencies certified to participate in the Medicare program.

- Staff members providing interim medical monitoring and treatment services to consumers are to meet all of the following requirements: be at least 18 years of age, not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under, not be a usual caregiver of the consumer, and be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.
- ◆ Respite services are expanded by adding medical respite, expanding potential providers, and increasing rates for all providers. In addition, criteria are added to require safety procedures during the provision of respite care. Respite services provided by home health agencies, home care agencies, and other nonfacility providers are divided into specialized respite, group respite, and basic individual respite, with separate rates of payment.
 - "Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse. "Group respite" is respite provided on a staff-to-consumer ratio of less than one to one and "basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.
 - This manual release identifies new procedure codes and unit reimbursement upper limits. Provider agencies are responsible for communicating rate changes to consumers' service workers and case managers. Changes in rates must be ordered and approved in the consumers' service plans prior to billing.
- ◆ The reimbursement rates for personal emergency response and consumer-directed attendant care providers are increased by 0.7 percent. HCBS waiver home health providers shall be paid the maximum Medicare rate. This manual release updates procedure codes that received a 0.7% increase to the rates or rate caps. Provider agencies are responsible for communicating rate changes to consumers' service workers and case managers. Changes in rates must be ordered and approved in the consumers' service plans prior to billing.
- ◆ *A Financial and Statistical Report for Purchase of Service Contracts*, form 470-3449, is required to be filed annually to reconcile respite services for the following types of respite providers:
 - Home health agencies providing group respite.
 - Non-facility providers of specialized, basic individual and group respite.
 - Camps.
 - Home care agencies providing specialized, basic individual and group respite.

The following changes are effective May 1, 2001.

- ◆ Adult day service providers enrolled to provide consumer-directed attendant care services are no longer required to submit a detailed cost report.
- ◆ Persons with durable power of attorney for medical care are added to the list of people who can agree to consumer-directed attendant care services on behalf of a consumer.
- ◆ Who may be a home and vehicle modification service provider is redefined to add community businesses as a provider type. Who may be a nursing provider is redefined to be agencies that are certified to participate in the Medicare program as home health agencies.
- ◆ Policy governing consumer-directed attendant care services is revised to allow the assistance of consumers with job-related tasks at the direction of the Health Care Financing Administration.
- ◆ Policy is revised to specifically define covered home and vehicle modifications. Only the modifications listed will be covered.
- ◆ The terms “individual comprehensive plan” and “case plan” are replaced by “service plan” throughout the manual.
- ◆ Supported employment services are redefined to meet the needs of the consumers served. Policy regarding reimbursement rates and payment methodology is also revised.
- ◆ Policy governing the 180-day process for accessing payment slots is revised to allow quicker access to the waivers and to reduce the number of exceptions to policy.
- ◆ Policy governing eligibility in the Mental Retardation waiver is revised to provide that persons need only have a diagnosis of mental retardation, rather than a primary diagnosis of mental retardation, to qualify for the waiver. Consumers in the Mental Retardation waiver also no longer need to have their names placed on a referral list.

Dates Effective

July 1, 2000 and May 1, 2001

Material Superseded

Remove the following pages from the ***HCBS MENTAL RETARDATION WAIVER SERVICES MANUAL***, and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents	
4, 5	July 1, 1999
6	April 1, 2000

Chapter E

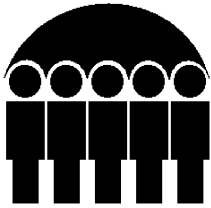
1-46	July 1, 1999
47-60	12/98
61-66	7/98
67-89	July 1, 1999
90	February 1, 2000
91	July 2, 1999

Chapter F

1	July 1, 1999
4	April 1, 2000

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-202
Employees' Manual, Title 8
Medicaid Appendix

February 21, 2003

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HCBS MENTAL RETARDATION WAIVER MANUAL***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 2, 5 through 12, 13 through 17, 26 through 34, 36, 38, 43 through 50, and 110 through 113, revised; and pages 12a, 114, and 115, new, and Chapter F, *Billing and Payment*, pages 1, 4, 5, 7, 8, 15, 17, and 19, revised.

Summary

The MR Waiver Provider Manual has been updated to reflect the following:

- ◆ Form 470-2917, *Medicaid HCBS Waiver Provider Application*, is revised to change its layout and structure and to provide more clarity in completion.
- ◆ The form for consumer application for the waiver is now the *Health Services Application*, form 470-2927.
- ◆ Effective January 1, 2003, the limit of 180 days to access waiver services after application is limited. To keep an assigned slot, applicants must make reasonable efforts to obtain services.
- ◆ Central point of coordination staff have been added to the list of members who may be present at the interdisciplinary team.
- ◆ It is being clarified that the service plan shall include:
 - Both waiver and non-waiver services need to be included on.
 - The date span of the services.
- ◆ For CDAC, children under the age of 18 must have a parent or guardian present during the service provision.
- ◆ For supported community living services:
 - Effective October 1, 2002, an exception to policy is no longer required for four-person supported home.
 - Service workers are no longer required to request a variance for children when the hours go over 52. The service worker must record this in the service file to reflect the need for increase but does not have to get prior approval.
- ◆ Effective October 1, 2002, supported employment is also available to consumers ages 16 through 18, due to legislation (2002 Iowa Acts, Chapter 1120).

- ◆ The *Claim for Targeted Medical Care*, form 470-2486, is revised to include a column that identifies the specific rate for any Medicaid service. This revision will assist the provider in computing accurate total charges.
- ◆ Names are changed from the “Division of Medical Services” to the “Bureau of Long Term Care” and from “Consultec” to “ACS.”

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from *HCBS MENTAL RETARDATION WAIVER MANUAL* and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 4)	July 1, 2000
Chapter E	
2	July 1, 2000
5-12	5/01
13-17, 26, 27	July 1, 2000
28, 29	May 1, 2001
30	July 1, 2000
31	May 1, 2001
32	July 1, 2000
33, 34	May 1, 2001
36	July 1, 2000
38	May 1, 2001
43-50	9/00
110-113	July 1, 2000
Chapter F	
1, 4	July 1, 2001
5	July 1, 1999
7, 8	2/99
15	April 1, 2000
17, 19	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

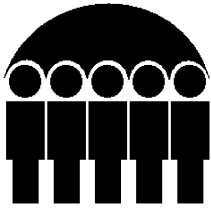
www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-237

Employees' Manual, Title 8

Medicaid Appendix

October 22, 2003

HCBS MENTAL RETARDATION WAIVER MANUAL TRANSMITTAL NO. 03-2

ISSUED BY: Bureau of Long Term Care, Division of Medical Services

SUBJECT: ***HCBS MENTAL RETARDATION WAIVER MANUAL***, Table of Contents (pages 4, 5, and 6), revised; Chapter E, *Coverage and Limitations*, pages 19 through 26, 27, 37, 38, 50, 51, 53 through 64, 95, 96, and 110 through 115, revised; and pages 26a, 38a, 38b, 64a, 96a, and 116, new; Chapter F, *Billing and Payment*, pages 1, 6, and 17, revised; and page 8a, new.

Summary

Chapter E has been revised as follows:

- ◆ Three new services are added to the MR waiver: transportation, prevocational services, and adult daycare. The manual has been updated to provide a description of these services, define the procedure codes for billing the services, and describe who can be a provider of these services.
- ◆ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated uniform national standards for health information. Consequently, Iowa Medicaid initiated a review of all local "W" HCPCS codes that are unique to Iowa Medicaid. These local codes are being replaced by HCPCS Level II codes. The codes for home health aide and nursing services are being changed for the waivers.
- ◆ The manual is revised to update policy for providers that complete a cost report for depreciation to be required at \$5000 instead of \$500. If a depreciable asset has at the time of acquisition an estimated useful life of at least two years and a historical cost of at least \$5000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation.
- ◆ The rent subsidy program is being revised due to rule changes as to who can access this program. The program now restricts eligibility for rent subsidy to people at risk of nursing facility placement. Children will no longer be able to access this program. The application process and eligibility determination process is also been updated.

Chapter F has been revised to:

- ◆ Add instructions electronic claim filing.
- ◆ Add form 470-3969, *Claim Attachment Control*, and instructions. This form is used to submit paper attachments for an electronic claim.
- ◆ Correct the sample of form 470-3744, *Provider Inquiry*.

Date Effective

Immediately

Material Superseded

Remove the following pages from ***HCBS MENTAL RETARDATION WAIVER MANUAL*** and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents	
4	February 1, 2003
5, 6	July 1, 2000
Chapter E	
19-21	May 1, 2001
22	July 1, 2000
23	May 1, 2001
24, 25	July 1, 2000
26	February 1, 2002
27	February 1, 2003
37	May 1, 2001
38	February 1, 2003
50	9/00
51	May 1, 2001
53-58	July 1, 2000
59-64	May 1, 2001
95, 96	July 1, 2000
110-115	July 1, 2003
Chapter F	
1	July 1, 2003
6	July 1, 1999
17	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
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If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.